EMPLOYEE ENROLLMENT GUIDE

Understanding Your Health Coverage

Washington State
Health Care Authority
Public Employees Benefits Board

Forms Inside!

HCA 50-100 (12/07)

Contact the Plans

Medical Plans	Web site address	Customer service phone numbers	TTY Customer service phone numbers (deaf, hard of hearing, or speech impaired)
Aetna Public Employees Plan	www.aetnahca.com	1-800-222-9205	1-800-628-3323
Group Health Classic and Value	www.ghc.org/pebb	206-901-4636 or 1-888-901-4636	711 or 1-800-833-6388
Kaiser Permanente Classic and Value	www.kaiserpermanente.org	Portland: 503-813-2000 All other areas: 1-800-813-2000	1-800-735-2900
Uniform Medical Plan	www.ump.hca.wa.gov	1-800-762-6004 or 425-670-3000	1-888-923-5622 or 360-923-2701

Dental Plans	Web site address	Customer service phone numbers
DeltaCare, administered by Washington Dental Service	www.deltadentalwa.com/pebb.htm	1-800-650-1583
Uniform Dental Plan	www.deltadentalwa.com/pebb.htm	1-800-537-3406
Willamette Dental	www.WillametteDental.com/WApebb	1-800-360-1909

Contact the plans for help with:

- Specific benefit questions.
- Choosing a doctor or dentist.
- To verify if your doctor or other provider contracts with the plan.
- Drug formulary.
- I.D. cards.
- Claims.

Contact your employer for help with:

- Changing your name, address, and phone number.
- Finding forms.
- Adding/removing dependents.
- Payroll deduction information.

Contact PEBB for help with:

- Eligibility questions and changes (Medicare, student, divorce).
- Eligibility complaints/appeals.

Blue ink indicates information only for subscribers who have dental coverage.

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To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

Blue ink indicates information only for subscribers who have dental coverage.

Glossary

Allowed charges
The maximum amount your insurance plan will pay for covered services, treatments, or supplies.

Annual deductible
The amount you must pay each calendar year before the plan pays benefits for covered expenses. Most plans described in this guide do not have an annual deductible, except the value managed-care plans, Uniform Medical Plan (UMP), and Uniform Dental Plan (UDP). Some benefits may not apply to the annual deductible. Refer to your plan's certificate of coverage for details.

Annual out-of-pocket maximum
The most you would pay toward the majority of covered expenses in a calendar year. Once you've reached your out-of-pocket maximum, the plans pay 100 percent of most covered expenses for the rest of the calendar year. For most medical plans, these expenses apply to the out-of-pocket maximum:

- Inpatient hospital admissions
- Ambulance service
- Outpatient/day surgery and ambulatory surgery centers
- Physical, occupational, speech, and massage therapy
- Organ transplants
- Skilled nursing facility services

Value managed-care plans and UMP have higher out-of-pocket limits than classic managed-care plans, and the Aetna Public Employees Plan. Uniform Dental Plan has higher out-of-pocket limits than the managed-care dental plans. Refer to your plan's certificate of coverage for details.

Certificate of coverage
A legal document that describes eligibility, covered services, limitations and exclusions, utilization procedures, and other plan provisions. The medical or dental plan will provide you with a certificate of coverage after you enroll.

Certificate of creditable coverage
A legal document that states you had health coverage during a certain time period.

Coinsurance
The percentage you pay toward health care claims when your plan pays benefits at less than 100 percent.

Copay
The fixed cost you pay for services at the time you receive care. Most plans described in this guide require a copay (sometimes called a "copayment") when you see network providers or receive prescription drugs.

Drug formulary
(Some plans call this a preferred drug list.) A list of approved prescription drugs that the plan will cover. Each plan has a different formulary. Contact the plans for details.

Emergency
Conditions with symptoms so severe that most people would reasonably expect that, without immediate health care attention, the condition would:

- Seriously jeopardize the individual's physical or mental health.
- Seriously impair bodily functions.
- Cause a serious dysfunction of any body organ or part.

Your plan has the right to determine whether the symptoms indicate a medical emergency. See the plan's certificate of coverage for details.

HCA
The Health Care Authority (HCA) is the state agency that develops and administers health insurance programs for state and higher-education employees, retirees, and their dependents, as well as other eligible groups that choose to purchase Public Employees Benefits Board (PEBB) coverage. The HCA provides medical, dental, life, and long-term disability insurance coverage to eligible enrollees through the PEBB program. PEBB enrollees receive their benefits through private health plans that contract with the HCA, and the self-insured Uniform Medical Plan, Aetna Public Employees Plan, and Uniform Dental Plan. The PEBB is responsible for designing and approving benefits and eligibility for public employees, retirees, and their dependents, in accordance with state and federal laws.

Hospice care
Medical, therapeutic, nursing, or counseling services for a terminally ill patient and family enrollees by a public or private agency or organization for that specific purpose.

Inpatient
An enrollee who has been admitted to the hospital, receives inpatient room and board services, and is expected to remain 24 hours or longer.

Maximum plan payment for medical plans
Some services have specific calendar year or lifetime benefit limitations, as detailed in each plan's certificate of coverage.

Network
A group of health care providers in a certain geographic location (including doctors, hospitals, and other health care professionals and facilities) who have contracted to provide services to a health plan's members at negotiated rates.

Open enrollment
The period of time each year when you may change medical and/or dental plans and add eligible dependents to your coverage without providing proof of previous coverage. Changes begin January 1 of the following year.

Outpatient
A patient who receives covered services inside or outside a health care facility under a provider's direction, but is not admitted as an inpatient.

Premium
The monthly amount PEBB enrollees pay for the cost of their health insurance. Premiums vary in cost depending on the health plan and the number of family members covered.

Primary care provider (PCP)
The doctor or nurse you choose to see for regular office visits, and who may refer you to and coordinate your care with specialists.

Some PEBB managed-care plans require each enrollee to have a primary care provider, who may be in family practice, internal medicine, or pediatrics. For some plans, women may choose obstetricians or gynecologists for their PCP. However, each covered family member may have a different PCP. If you do not choose a PCP, some plans will choose one for you based on where you live. You may change your PCP during the year. The list of providers may be updated periodically.

Provider
A health care practitioner or facility operating within the scope of a license.

Specialist
A provider of specialized medicine, such as a cardiologist or a neurosurgeon.

Subnetwork
A provider group (such as hospitals, physicians, specialists, and other providers) whose members may restrict your choice of referred specialists to only those within that same provider group.

Welcome

The Washington State Health Care Authority (HCA) is the agency that purchases and coordinates health insurance benefits for public employees through the Public Employees Benefits Board (PEBB) Benefits Services program. This guide provides you (the subscriber) with some basic information about your medical and dental coverage and will help you in making your health plan decisions.

If you are a state agency or higher-education employee, you have medical and dental coverage. If you are employed by a school district, county or city government, or other employer group, your employer may offer medical only or medical and dental. Check with your payroll, personnel, or benefits office to learn what coverage your employer offers.

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HCA Administrator

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Cost Containment

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K-12 Representative

Margaret Stanley
Benefits Management/
Cost Containment

Yvonne Tate*
Benefits Management/
Cost Containment

*Non-voting member

The benefits described in this guide are brief summaries. For a complete description of PEBB benefits, refer to the health plan's certificate of coverage. (See the "Glossary" for definition.) You will receive your certificate of coverage directly from your plan after you enroll.

Some benefits described in this guide are based on federal or state laws. We have attempted to describe them accurately, but if there are differences, the laws will govern.

You may find the Public Employees Benefits Board's existing law in chapter 41.05 of the Revised Code of Washington (RCW), and rules in chapters 182-04, 182-08, 182-12, 182-13, and 182-16 of Washington Administrative Code (WAC). These are available on the Office of the Code Reviser's Web site at slc.leg.wa.gov and on the PEBB Web site at **www.pebb.hca.wa.gov**.

Blue ink indicates information only for subscribers who have dental coverage.

How to Enroll

To enroll in or waive PEBB coverage, complete and submit the enclosed Employee Enrollment/Change form. If you wish to enroll in PEBB coverage, and your employer offers medical and dental, you must choose a medical plan and a dental plan when you fill out your enrollment form. State agencies and higher-education institutions offer dental coverage but some school districts, city and county governments, and other employer groups do not. Please check with your payroll, personnel, or benefits office. If your employer does not offer dental coverage, complete and submit the enclosed *Employer Enrollment/Change for Medical Only Groups* form.

Follow these steps to choose a plan:

1. Check "Medical Plans Available by County" in this guide to find which medical plans are offered in your county of residence .
2. Gather information.
   a) Read about the different types of medical and dental plans PEBB offers. Descriptions of the medical plans begin on page 18. If your employer offers dental coverage, also read description of the dental plans on page 43. Call the plans directly with questions about specific benefits, drug formularies, or provider participation. The health plan phone numbers and Web addresses are listed at the front of this guide.
   b) Compare the health plans' monthly premiums on page 19 (there is no employee contribution for dental coverage).
   c) Check the provider directory on the PEBB Web site at **www.pebb.hca.wa.gov** to find out if your provider participates with the medical plan you choose. Then call the plan directly to confirm your doctor's participation. If you are choosing a doctor or other health care provider for the first time, be sure to find out if he or she is accepting new patients.
3. Choose your medical and dental plan (if your employer offers dental coverage). There are no restrictions or waiting periods for preexisting conditions under any of the PEBB medical or dental plans. You must enroll all eligible family members in the same medical and/or dental plan. However, each family member may have a different doctor or other health care provider.
4. If you enroll family members, complete the appropriate certification form(s) when required.
5. Complete the enrollment form and return it to your personnel, payroll, or benefits office **within 31 days** after the date you become eligible for benefits.

If you don't submit a completed enrollment form within 31 days after you become eligible for health benefits, we will enroll you in the Uniform Medical Plan (UMP) as a single subscriber. If your employer offers dental coverage and you do not enroll within 31 days, we will also enroll you in the Uniform Dental Plan as a single subscriber. However, claims for benefits will be denied until you submit a completed enrollment form. Your next opportunity to change plans or add dependents will be the next open enrollment period. For exceptions, refer to pages 14–16.

Flexible Spending Account

Washington Flex is a medical flexible spending account (FSA) program that allows benefits-eligible state and higher-education employees to set aside money from each paycheck—before taxes—to pay for out-of-pocket health expenses. This reduces both your annual taxable income and the amount you pay for out-of-pocket health expenses.

If you want to set up an FSA, you must enroll **within 31 days** after you become eligible for benefits or wait until the next annual open enrollment period.

You decide how much you want to contribute per pay period when you enroll. (The minimum annual contribution is $240; the maximum is $2,400.)

The full amount of your calendar year FSA contribution is available after you enroll. You may use your FSA to reimburse yourself for out-of-pocket medical, dental, and vision expenses allowed by the Internal Revenue Service (IRS). You may not pay premiums from your account, but you can use it for deductibles, copays, and coinsurance. Your own expenses and those of family members who qualify as dependents under IRS rules may be reimbursed from your account.

Application Software, Inc. (ASI) is our 2008 FSA administrator. For more information and forms, go to ASI's Washington Flex Web site at **www.asiflex.com/pebb** or call ASI at 1-800-659-3035. Send questions via e-mail to **asi@asiflex.com**.

How to Enroll

Dependent Care Assistance Program

The Dependent Care Assistance Program (DCAP) offers state and higher-education employees an opportunity to reduce taxable income by setting aside money from each paycheck, before taxes, to pay for dependent care expenses.

Qualifying dependents include a dependent under age 13 who qualifies as an Internal Revenue Service (IRS) dependent; any other IRS-recognized dependent who is physically and/or mentally incapable of self-care; or a spouse who is physically and/or mentally incapable of self-care.

If you want to take advantage of the DCAP, you must enroll within **31 days** of employment or wait until the next annual open enrollment period.

You decide how much you want to set aside each pay period when you enroll. There is a $5,000 limit on the total amount of tax-free dependent care assistance that you can receive in any year ($2,500 if you and your spouse file separate tax returns).

Application Software, Inc. (ASI) is our 2008 DCAP administrator. For more information and forms, go to ASI's Washington Flex Web site at **www.asiflex.com/pebb** or call ASI at 1-800-659-3035. Send questions via e-mail to **asi@asiflex.com**.

I.D. Cards

After you enroll, your plan(s) will send you an identification (I.D.) card to show to providers when you receive care.

If you have questions about your I.D. card, contact your plan directly.

(The Uniform Dental Plan does not issue I.D. cards.)

Blue ink indicates information only for subscribers who have dental coverage.

Questions and Answers

Covering Dependents

Are my family members eligible?

If you are enrolling yourself, you may also enroll your legal spouse or qualified domestic partner, and eligible children. See the "Dependents" section on page 13 for the definition of eligible dependents.

Are there additional forms required to enroll my dependents?

You must complete a certification form (available on PEBB's Web site or from the PEBB Benefits Services Program) if you want to add any of the following:

- A spouse or qualified domestic partner.
- A student over age 19.
- A dependent over age 19 with a disability.
- An extended (legal) dependent.

See "Dependents" on page 13 for eligibility and certification form requirements.

One of my children attends college. Can I still enroll in a managed-care plan not offered in the county where he or she goes to college?

Yes. If your student dependent(s) over age 19 lives outside your plan's service area temporarily while attending high school, an accredited secondary school, college, university, vocational school, or school of nursing, he or she may receive benefits through any licensed provider. Claims for those providers will be paid as if the service had been received through plan-designated providers.

Preexisting Conditions

There are no preexisting condition restrictions or waiting periods for any PEBB-sponsored medical or dental plan.

Refer to your plan's certificate of coverage (COC) for details. Your dependent will be responsible for the same copayments or coinsurance amounts that apply to enrollees who receive services in their plan area. However, the plan must authorize routine care and all other services in advance, except when emergency or urgent care is needed.

If I die, can my surviving dependents continue PEBB coverage?

Yes. See "Options for Continuing Coverage" on page 16 for details. Dependents who waived coverage before your death must complete the appropriate enrollment form within **60 days** after your death to either enroll in or continue to waive coverage. If you are an emergency services personnel killed in the line of duty, your dependents have 180 days to either enroll in or waive coverage.

What happens if my covered family member is no longer eligible?

You, your dependent, or your beneficiary must report eligibility changes such as death, divorce, or when a dependent is no longer eligible as defined in Washington Administrative Code (WAC) 182-12-260 to us within **60 days** of the event. See "Removing Dependents" on page 14 and "Options for Continuing Coverage" on page 16 for more information.

Can my dependent temporarily continue coverage if he or she is no longer eligible under PEBB rules?

It depends, based on the reason he or she lost eligibility. See "Options for Continuing Coverage" on page 16 for details.

What should I do if my spouse or qualified domestic partner is also eligible for PEBB coverage as an employee?

PEBB does not allow dual coverage. Enrolled family members may be listed under one account, but not both. This means you could waive the medical coverage on your account and enroll on your spouse's or qualified domestic partner's account, or enroll under separate accounts. You will need to coordinate with your spouse or qualified domestic partner to decide who will cover any eligible dependent children.

Selecting a Plan

What medical plans are available?

See "Medical Plans Available by County" on pages 21-23.

What dental plans are available?

See "How the Dental Plans Work" on page 37.

How do the plans differ?

See "How the Medical Plans Work" on page 18 and "How the Dental Plans Work" on page 43.

How do I select the best medical and dental plans for my family?

See "Selecting the Best Medical Plan for You and Your Family" on page 20 and "Dental Benefits Comparison" on page 44.

Do my covered family members have to enroll in the same plan(s) I choose?

Yes. PEBB rules require all family members to enroll in the same plan.

Questions and Answers

Cost

How much do the plans cost?

If you are a state or higher-education employee, see the "2008 Monthly Premiums" chart on page 19. **If you are employed by a school district, city or county government, or another employer group, contact your payroll, personnel, or benefits office for premiums.** In addition to your monthly premiums, you must pay for any deductibles, coinsurance, or copayments under the plan you choose. See the certificate of coverage available from each plan for detailed information.

Premiums Paid With Pretax Dollars

If you are a state agency or higher-education employee, you may pay health plan premiums with pretax dollars from your salary. Internal Revenue Service code Section 125 allows us to deduct money from your paycheck before certain payroll taxes and your income tax are calculated. This rule allows for deductions including monthly premiums for your medical coverage, the state's medical flexible spending account, and for the state's dependent care assistance program. **If you are not a state or higher-education employee, please check with your payroll, personnel, or benefits office to see if your employer offers this benefit.**

Why should I pay my monthly health care premiums with pretax dollars?

While the difference is not very noticeable, you take home more money, because taxes are calculated after the premium is deducted. By paying for your coverage this way, you reduce your taxable income, which lowers your taxes and saves you money.

Do I need to sign up for a Section 125 deduction?

No. Your health care premiums will be automatically deducted from your earnings before taxes are calculated **unless you sign the Section 125 waiver form saying you do not want to pay your premiums with pretax earnings.** The waiver form is available in your agency's personnel, payroll, or benefits office.

Can I change my mind about participating in a Section 125 deduction?

Yes, but only during the annual open enrollment period and when there is a change in your family circumstances, such as:

- Marriage or divorce.
- Establishment or termination of a qualified domestic partnership.
- Addition of a new child to your coverage.
- Removal from coverage of a child who has reached PEBB's dependent age limit.

Your employer may also remove you from the Section 125 plan— with notice—if it is necessary to prevent excess tax deferral.

When would it benefit me not to have a Section 125 deduction?

If you have your health plan premiums, flexible spending account funds, or dependent care assistance program funds deducted before your taxes are calculated, the following benefits may also be affected:

- **Social Security**—If your base salary is under the $102,000 per year maximum, Section 125 participation will save you money now by reducing your social security taxes. However, if you are nearing retirement age, your lifetime social security benefit would be calculated using the lower salary.
- **Unemployment compensation**—Section 125 also reduces the base salary used to calculate unemployment compensation.

To waive your Section 125 option, complete the waiver form and return it to your agency's personnel, payroll, or benefits office.

Where can I get more information about Section 125?

For advice on your individual situation, you should talk to a qualified financial planner or your local Social Security Office.

Providers

How do I know if my doctor or hospital belongs to a plan?

You must call the plan directly. For medical or dental plans, refer to the telephone numbers listed at the front of this booklet. When you call the plan, be sure to mention that you are a PEBB state of Washington enrollee.

You may also search for providers, hospitals, and pharmacies that contract with the medical plans you're interested in on the PEBB Web site at **www.pebb.hca.wa.gov**. If a provider is listed, call the medical plan(s) to confirm his or her participation.

May I change providers after I have joined a plan?

Yes, although rules vary from plan to plan. Call your plan directly for details.

Do all members of my family have to use the same provider?

They can select the same provider, but it's not required. Each dependent may select his or her own provider available through the plan.

Blue ink indicates information only for subscribers who have dental coverage.

If I want the freedom to see any doctor or health care provider without a primary care provider referral, which plan should I enroll in?

The Uniform Medical Plan and the Aetna Public Employees Plan allow freedom of choice for all approved provider types. However, the Aetna Public Employees Plan requires you to use their nationwide network of providers.

You are not allowed to change plans during the year, even if your doctor, dentist, or health care facility leaves your plan during the plan year.

You will have to wait until the next annual open enrollment period to change your plan.

If you transfer from one agency or school to another during the plan year, you are not permitted to change plans, except in certain circumstances explained in "Changing Your Plans" on page 15.

Making Changes

When may I change plans?

See "Changing Your Plans" on page 15.

Who should I contact if I have a change of address?

You must contact your personnel, payroll, or benefits office **within 60 days** after the date you move. If the health plan you are enrolled in is no longer available to you, see "Changing Your Plans" on page 15 for more information.

May I waive my dependent's coverage during the year?

Yes, you may waive coverage for your dependent at any time during the year. However, if your dependent needs to reenroll in PEBB coverage, please see "Waiving Medical Coverage" on page 15 for details.

How do I enroll a new spouse or qualified domestic partner or child?

You must submit a revised *Employee Enrollment/Change* form and the appropriate dependent certification form(s) to your personnel, payroll, or benefits office **within 60 days** of the date your dependent became eligible for PEBB coverage. Otherwise, you must wait until the next open enrollment period to enroll your dependents. See "Adding Dependents" on page 14 for more information.

Coordination of Benefits

How does my PEBB coverage work with my other group medical or dental coverage?

If you are also covered through your spouse's or domestic partner's other comprehensive group health coverage, call the medical and/or dental plans directly to ask how they will coordinate benefits. Coordinating your PEBB plan's benefits with your other plan's benefits may save you money.

PEBB/HCA Administration

Who determines what PEBB benefits will be?

The Legislature establishes how much state money is available to spend on employee benefits. Then the Public Employees Benefits Board (PEBB) establishes eligibility requirements and approves the benefits plans for insurance and other benefits. The Board meets regularly to review benefit and eligibility issues and plan for the future. Board members are listed on page 6.

Who administers the day-to-day operations of these programs?

The Health Care Authority (HCA) purchases benefits within the amount of money funded by the Legislature. The HCA contracts with insurance companies and manages its own self-insured plans—the Uniform Medical Plan, Aetna Public Employees Plan, and Uniform Dental Plan, to provide a choice of quality health care options and responsive customer service to its members. The HCA's PEBB Benefits Services Program administers benefit eligibility and enrollment.

Who do I call if I have a question about an appeal?

Call your medical or dental plan for answers to questions about your plan's appeal process.

If you've already filed an appeal and are not satisfied with the decision, contact your plan about further appeal rights.

If your questions are not answered by your plan within its appeal timelines, you may call the PEBB Benefits Services Program at 1-800-200-1004 for assistance.

Eligibility and When Coverage Begins

New Employees

The following employees of state government, higher education, participating K-12 school districts, educational service districts, and employer groups are eligible to apply for PEBB coverage.

Permanent Employees

If you are expected to work at least half-time per month for more than six months, your coverage will begin on the first day of the month following your date of employment. (An exception is made if you begin work on the first working day of the month; in this case, coverage begins that day.)

Nonpermanent Employees

If you work at least half-time and you are expected to be employed for no more than six months, you are a nonpermanent employee. If your employment continues beyond the initial six-month period, you become eligible for coverage. Your coverage would begin on the first day of the seventh calendar month of employment.

Career Seasonal Employees

If you work at least half-time per month during a designated season, and you have an understanding of continued employment year after year, you are eligible for coverage. Your coverage will begin on the first day of the month following your date of employment. (An exception is made if you begin work on the first working day of the month; in this case, coverage begins that day.) If you work a designated season that extends nine or more months, you are eligible for the employer contribution during the break between seasons. If you work a designated season for less than nine months, you are not eligible for the employer contribution during the break between seasons of employment, but you may continue coverage by paying your own premiums.

Instructional Year Employees

If you work half-time or more on an instructional year (school year) or equivalent nine-month basis, you are eligible for coverage. Your coverage will begin on the first day of the month following your date of employment. (An exception is made if you begin work on the first working day of the month; in this case, coverage begins that day.) You are eligible for the employer contribution for coverage during the off-season following each instructional year period of employment.

Part-Time Faculty and Part-Time Academic Employees

If you work at least half-time at one or more state institutions of higher education on a quarter/semester to quarter/semester basis, you become eligible for coverage beginning with the second consecutive quarter/semester. When determining eligibility, spring and fall are considered consecutive quarters/semesters. Your coverage will begin on the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment. (An exception is made if you begin work on the first working day of the month; in this case, coverage begins that day.)

Part-time academic employees of community and technical colleges who have a reasonable expectation of continued employment are eligible for the employer contribution for benefits during the quarter break immediately following the end of one academic year or equivalent nine-month season.

Appointed and Elected Officials

If you are a legislator or an elected or full-time appointed official of the legislature or executive branch of state government, you are eligible for coverage. If you are a legislator, your coverage will begin on the first day of the month your term begins or the first working day of the month. (An exception is made if the date your term begins is the first working day of the month; in this case, coverage begins that day.)

If you are an elected or full-time appointed official of the legislative or executive branches of state government, your coverage will begin the first day of the month your term begins or the first day of the month you take the oath of office, whichever is earlier. (An exception is made if your term begins or you take your oath of office on the first working day of a month; in this case, coverage begins that day.)

Judges

If you are a Supreme Court Justice or a Court of Appeals or Superior Court judge, you are eligible for coverage. Your coverage will begin on the first day of the month following the date your term begins or the first day of the month you take the oath of office, whichever is earlier. (An exception is made if your term begins or you take the oath of office on the first working day of the month; in this case, coverage begins that day.)

Employees of Participating Employer Groups

Medical coverage begins as described above, unless the effective date of insurance coverage for eligible employees was determined by the terms of employment or collective bargaining agreement and those

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terms related to the effective date are approved by the HCA. Participation of the bargaining unit or non-represented employees is subject to approval by the HCA.

When Coverage Begins for Employees Returning from Leave Without Pay

Employer contributions for PEBB coverage will resume on the first day of the month you return to work and are in pay status for eight or more hours. You will be reimbursed if you have paid your own premiums for any month that you were eligible for a premium contribution by your employer.

Dependents

As a PEBB subscriber, you may enroll the following dependents:

- Your lawful spouse. You must complete a *Spouse or Qualified Domestic Partner Certification* form.
- Your domestic partner qualified by the PEBB *Declaration of Marriage or Qualified Domestic Partnership*. You must complete a *Spouse or Qualified Domestic Partnership Certification* form.
- Your same-sex domestic partner may also be qualified through the *Certificate of State Registered Domestic Partnership* or registration card issued by the Washington Secretary of State's Office.
- Your dependent children through age 19. The term "children" includes your biological children, stepchildren, legally adopted children, children for whom you have assumed a legal obligation for total or partial support in anticipation of adoption of the child, children of your qualified domestic partner, or children specified in a court order or divorce decree.

  Married children who qualify as your dependents under the Internal Revenue Code and extended (legal) dependents approved by PEBB are included.

  For extended dependents to qualify for enrollment, you must submit a completed *Extended Dependent Certification* form. You must also demonstrate legal custody or legal guardianship for the child with a court order and the child:

  - Must have his or her official residence with you or your spouse or qualified domestic partner.
  - Must not be a foster child for whom support payments are made to you through the Department of Social and Health Services (DSHS) foster care program.

- Your children beyond age 19 under the following conditions:
  - Dependent children ages 20 through 23 who are attending high school or registered students at an accredited secondary school, college, university, vocational school, or school of nursing. Dependent student coverage continues year-round for students who attend three of the four school quarters or two of three school semesters, and for three months after graduation as long as you are covered at the same time, your dependent has not reached age 24, and he or she meets all other eligibility requirements. You must submit a completed *Student Certification/Change* form when you enroll your student annually, and whenever requested by the PEBB Benefits Services Program.
  - Dependent children of any age with disabilities, developmental disabilities, mental illness, or mental retardation who are incapable of self-support are eligible for PEBB coverage if their condition occurred before age 20 or while the dependent was eligible as a student under PEBB rules.

    You must provide proof that the disability occurred before the dependent turned age 20 or while he or she was eligible for student coverage under PEBB rules. For children enrolled in PEBB insurance, this proof must be provided by submitting a completed *Certification of Dependents With Disabilities* form to the PEBB Benefits Services Program for approval by the health plan within **60 days** of the child turning age 20 or ending student eligibility. For children not enrolled in PEBB insurance, ages 20 or older, you must provide proof the disability occurred before age 20 or during student eligibility at the time of PEBB enrollment. You must submit this proof with a completted *Certification of Dependents with Disabilities* form to us for approval by the health plan within **60 days** of the child turning age 20 or ending student eligibility. Proof of ongoing eligibility will be requested periodically by PEBB on behalf of the plan.

- Your dependents who were previously covered under a K-12 or employer group health plan and who are not otherwise eligible for PEBB coverage may continue coverage under a PEBB plan for up to 36 consecutive months. To be eligible for this continuation of coverage, the PEBB plan must replace a K-12 or employer group health plan with no lapse in coverage.

Eligibility and When Coverage Begins

Registered students over age 19 who attend a school outside of their plan's service area may receive network-level benefits through any licensed provider. UMP enrollees may receive out-of-network benefits from any approved provider type.

Benefits are administered differently from plan to plan. Contact your plan for details.

Adding Dependents

If you add eligible dependents, they will be covered under the same medical and/or dental plan(s) you choose. See "Medicare Entitlement" on page 17 for if you or one of your dependents is entitled to Medicare.

You may add family members to your coverage during the year if you have a change in family status. To add an eligible dependent, you must send a completed *Employee Enrollment/Change* form and appropriate dependent certification form(s), if required, **within 60 days** of the event. See "Dependents" on page 13 for details on required certification forms.

When you add an eligible dependent to your PEBB coverage due to one of the following situations, his or her coverage will begin as noted:

- **Marriage or establishment of a qualified domestic partnership**—Coverage begins the first of the month following marriage or declaration/certification of the partnership.
- **Newborn children**—Coverage begins on the date of birth.
- **Adopted children**—Coverage begins on the date you assume legal obligation for support in anticipation of adoption.
- **Dependent students**—Coverage begins the first day of the month of the quarter/semester in which the student registers.
- **Dependents with disabilities**—Coverage begins on the first day of the month eligibility is established or the first of the month following certification.
- **Dependents who previously waived PEBB coverage**—Coverage begins the first day of the month after other comprehensive group coverage ends.

Dependents who previously waived PEBB coverage and lose other medical coverage must enroll in a PEBB plan **within 60 days** of the date their other coverage ends. Dependents must provide proof of comprehensive group coverage since the most recent PEBB open enrollment period.

When a new dependent enrolls before the 16th day of the month, you pay the full month's premium; otherwise, the new premium will begin with the next full calendar month.

You may also add eligible dependents during the annual open enrollment period. During open enrollment, proof of a dependent's previous other medical coverage is not required. Open enrollment occurs each fall, and coverage changes begin on January 1 of the following year.

If the Washington State Department of Social and Health Services (DSHS) has formally determined that the eligible dependent is more cost-effectively enrolled in PEBB medical than a medical assistance program, then the subscriber can add the dependent to the account **within 60 days** of the determination.

Note: Surviving dependents of emergency services personnel cannot add newly acquired dependents.

Removing Dependents

You must notify PEBB in writing **within 60 days** after your spouse, qualified domestic partner, or child is no longer an eligible dependent under WAC 182-12-260. The following are examples of events that affect dependent eligibility:

- Divorce. Provide a copy of the decree.
- Termination of your qualified domestic partnership. If you registered your same-sex domestic partnership with the Washington Secretary of State's Office, provide a copy of the *Certificate of Termination*.
- Death.
- Your dependent student is no longer enrolled in school.
- Your dependent with disabilities becomes capable of self-support. Eligibility ends on the last day of the month in which the child became capable of self-support. Children ages 20 and older who become capable of self-support cannot regain eligibility for PEBB coverage if they later become incapable of self-support.

Dependents may temporarily continue their PEBB enrollment after they are no longer eligible, as long as you notify PEBB of the dependent's ineligibility in writing within the **60-day** period after eligibility ends. Options for continuing coverage vary, depending on the reason eligibility was lost. See "Options for Continuing Coverage" on page 16 for more information.

If you misrepresent or do not notify PEBB of changes that result in your dependent's loss of eligibility (including student status) **within 60 days** of the change, your dependent's coverage may be retroactively terminated. You must pay the cost of any health care services received during the time the family member was not eligible for coverage.

Blue ink indicates information only for subscribers who have dental coverage.

In addition, PEBB rules limit refunds of overpayments of premiums to three months.

We may request verification of PEBB eligibility at any time.

Waiving Medical Coverage

Eligible employees may waive PEBB-sponsored medical coverage if they are covered by another health plan. However, **if you waive coverage for yourself, medical coverage will automatically be waived for all dependents.**

If you are a state agency or higher-education employee who is eligible for PEBB benefits, you cannot waive dental coverage for yourself. You may waive dental coverage for family members if they have other continuous comprehensive group dental coverage.

To waive medical coverage, you must submit a completed enrollment form and certify that you have other continuous, comprehensive group medical coverage in the Signature section.

If you have other comprehensive group coverage, you should check the coordination of benefits rules for your other coverage and compare the advantages and disadvantages of participating in one or both plans.

Once you or your dependents waive coverage, you may reenroll in PEBB coverage:

- During the next open enrollment period. You may reenroll or add eligible dependents during open enrollment without proof of continuous, comprehensive group coverage.
- Within **60 days** after the loss of other medical coverage if you provide proof that you and your dependent(s) had other continuous coverage in a comprehensive group medical plan.
- If you have a qualifying change in family status, such as:
  - Marriage or divorce.
  - Establishment or termination of a qualified domestic partnership.
  - Birth or death of an eligible family member.
  - Adoption (or placement for adoption).
  - A dependent's eligibility ends.
  - When the Department of Social and Health Services (DSHS) formally determines that you and/or your eligible dependents are more cost-effectively enrolled in PEBB medical than a medical assistance program.

Re-enrollment must be requested **within 60 days** of the change in family status. For example, if you have a birth, you may also enroll your spouse who previously waived medical coverage as long as you request the enrollment **within 60 days** of the child's birth date. You may also change your medical and dental plan with a qualifying change in family status.

Note: K-12 employees may ***not*** be permitted by their school district to re-enroll until the next open enrollment or renegotiation period.

Changing Your Plans

Your coverage is for an entire year (January 1 through December 31), unless you waive coverage. However, you may change plans during the year in the following situations:

- If you have a qualifying change in family status, you must submit an enrollment form (and appropriate certification forms, if required) **within 60 days** of the event. Examples include:
  - Marriage or divorce.
  - Establishment or termination of a qualified domestic partnership.
  - Birth or death of an eligible family member.
  - Adoption (or placement for adoption).
  - Dependent's eligibility ends.
- If you move, you may change your plan enrollment **within 60 days** of your move under these conditions:
  - If your plan is no longer available, you may enroll in any plan available in your new location. If you do not select a new plan, we will enroll you and your covered dependents in the Uniform Medical Plan (UMP).
  - If a plan was not available to you, but is offered in your new location, you may enroll in that plan.

  All such plan enrollment changes usually begin the first day of the month after your move.
- If a court order requires you to provide medical coverage for an eligible spouse, qualified domestic partner, or child, you may change medical plans and add the family member. The change is effective the first day of the month after the PEBB Benefits Services Program receives a completed enrollment form with all necessary supporting documentation.
- If the Washington State Department of Social and Health Services (DSHS) formally determines that you and/or your eligible dependents are more cost-effectively enrolled in PEBB

Eligibility and When Coverage Begins

medical than a medical assistance program.

- If you are a seasonal employee whose off-season occurs during open enrollment, you may change plans **within 31 days** of returning to work.
- You may change medical plans when you or your eligible dependent becomes entitled to Medicare Part A and Part B, or enrolls in a Medicare Part D plan.
- During the annual open enrollment, usually held in the fall, with coverage changes beginning the following January 1.
- When you apply for retiree coverage (the change is on the same day retiree coverage begins).
- If the PEBB Appeals Manager determines that a continuity of care issue exists. Refer to WAC 182-08-198(2) for specific details.

Note: If the employee is having premiums taken from payroll on a pre-tax basis, a medical plan change will not be approved if it would conflict with provisions of the salary reduction plan under RCW 41.05.300.

You may **not** change plans in the following situations:

- If your provider or health care facility discontinues participation with your plan, you may not change medical plans until the next open enrollment period, except as provided in WAC 182-08-198 (2)(h). Your plan cannot guarantee that any one physician, hospital, or other provider will be available or remain under contract.
- If an employee transfers from one employing agency to another during the year, the enrollee is not permitted to change medical plans, except as outlined above or in WAC 182-08-197.

Know Your Benefits

You are responsible for knowing your benefits and your plan's rules for using providers, preauthorization, and medical review to avoid penalty or loss of benefits. You can find these rules in your plan's certificate of coverage.

When Coverage Ends

PEBB coverage ends on the last day of the month you are employed or your dependent loses eligibility under PEBB rules.

For information on continuation coverage options, contact your personnel, payroll, or benefits office. You may also contact thePEBB Benefits Services Program at 1-800-200-1004.

If you or a covered dependent is confined in a hospital or other medical facility when your coverage ends, contact PEBB **within 31 days** to determine whether you or your dependent qualifies for an extended benefit.

Options for Continuing Coverage

You, your dependents, or both may temporarily continue your PEBB coverage by self-paying your premiums after your eligibility ends. Options for continuing coverage vary, based on the reason eligibility was lost. See your plan's certificate of coverage for more information.

You must apply to continue your coverage **within 60 days** of the event that caused you to lose eligibility, or you will lose all rights to continue PEBB coverage. Here are your continuation of coverage options:

- The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.
- PEBB Extension of Coverage.
- Leave Without Pay (LWOP) coverage.
- PEBB-sponsored retiree coverage.

The first three options temporarily extend PEBB medical coverage in certain circumstances when you would otherwise lose group medical and dental coverage. Eligibility for COBRA continuation coverage is defined in federal law and the plan program is administered based on federal rules.

PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA. LWOP coverage is an alternative that may be appropriate in specific situations.

PEBB-sponsored retiree coverage is available only to retirees or surviving dependents who meet the eligibility criteria outlined in PEBB rules. (See WAC 182-12-171, 182-12-250, or 182-12-265.)

All four continuing coverage options are administered by the Health Care Authority (HCA). Refer to your *PEBB Initial Notice of COBRA and Continuation Coverage Rights* for specific details or call the PEBB Benefits Services Program at 1-800-200-1004.

If you enroll in a flexible spending account (FSA) in 2008 and later terminate employment, retire, or go on unpaid leave, your eligibility for your FSA may change. You may elect continuation coverage by contacting ASI, the PEBB program's FSA administrator, at 1-800-659-3035 or by sending an e-mail to **asi@asiflex.com**.

Blue ink indicates information only for subscribers who have dental coverage.

Medicare Entitlement

Medicare Parts A and B

If you or a covered family member becomes entitled to Medicare, contact the nearest Social Security Office to ask about the advantages of immediate or deferred Medicare enrollment.

For employees and their spouses or qualified domestic partners ages 65 and older, the PEBB medical plan will provide primary insurance coverage, and Medicare coverage will be secondary. However, employees ages 65 and older may choose to reject PEBB medical and choose Medicare as their primary insurer. If an employee does so, he or she cannot enroll in a PEBB medical plan. However, the employee will remain enrolled in PEBB dental, life, and long-term disability insurance coverage.

Medicare Part B

In most situations, employees and their spouses or qualified domestic partners can elect to defer Medicare Part B enrollment, without penalty, up to the date the employee terminates employment or retires. If your entitlement is due to a disability, contact Medicare regarding deferral. **If you are entitled to Medicare while you're still employed, and want Medicare as your primary coverage, you must notify the PEBB Benefits Services Program in writing.**

If you terminate employment or retire, Medicare will become the primary insurer, and any PEBB continuation coverage you elect becomes secondary.

Please contact the PEBB Benefits Services Program for information about retiree eligibility and benefit information.

Medicare Part D

Medicare Part D is available to people enrolled in Medicare Part A and/or Part B. It is a voluntary program that offers prescription-drug benefits through private plans. These plans provide at least a standard level of coverage set by Medicare.

PEBB's medical plans provide prescription-drug coverage that is as good as or better than the standard Medicare Part D coverage. This means that after you become entitled to Medicare Part A and/or B, you can choose to enroll in a Medicare Part D plan at a later date and you would not pay a late enrollment penalty.

If you choose to enroll in Medicare Part D, your PEBB medical plan may not coordinate prescription-drug benefits with your Medicare Part D prescription-drug plan.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985

COBRA requires most employers sponsoring group plans to offer employees and their families the opportunity for a temporary extension of health coverage at group rates when coverage ends because of certain "qualifying events."

If you have the right to continue group coverage, you must enroll within **60 days** of the event that led to your loss of PEBB coverage and pay your own premiums. COBRA premiums cost 2 percent more than other self-pay premiums. See your plan's certificate of coverage for details.

How the Medical Plans Work

The medical plans may differ in their costs, types of providers and facilities, referral practices, and guidelines. While the plans have a basic level of benefits, some plans offer additional benefits or lower copays at no additional cost. The value plans offer lower premiums if you are willing to pay more when you use health care services.

Note: The plans cover services provided by plan-designated alternative care providers if the services are within the scope of their license, covered benefits, and approved by the plan. Please check with the medical plans for information about coverage for a specific service.

The table below shows some general similarities and differences among the four types of PEBB medical plans.

Plan Features	Aetna Public Employees Plan	Classic managed-care plans	Value managed-care plans	Uniform Medical Plan
Annual deductible	No	No	Yes	Yes
Member usually pays a copay (set amount) for services	Yes	Yes	Yes	No
Member usually pays a coinsurance (percent of allowed fee) for services	No	No	No	Yes
Recommends selection of a primary care provider (PCP)	No	Yes	Yes	No
Member must use plan or plan-designated providers to receive payment for services	Yes	Yes	Yes	No
Plan may require PCP referral for some specialty care	No	Yes	Yes	No
Coverage for routine services outside of the service areas	No	No*	No*	Yes
Nationwide provider network	Yes	No	No	Yes
Worldwide emergency coverage	Yes	Yes	Yes	Yes
Secure e-mail access to your provider	No	Yes**	Yes**	No
Online access to your electronic medical records	No	Yes**	Yes**	No

* Plans may cover some routine services for student dependents and other enrollees who temporarily live outside of the service area.

**Not available in all areas. Check with the plan for details.

Blue ink indicates information only for subscribers who have dental coverage.

How the Medical Plans Work

2008 Monthly Premiums for State Agency and Higher-Education Employees

Please note: ***School district employees and those who work for a city, county, port, water district, hospital, etc. need to contact their personnel, payroll, or benefits office to get their monthly premium amounts.***

PEBB Medical Plans	Employee	Employee & Spouse*	Employee & Child(ren)	Employee, Spouse* & Child(ren)
Aetna Public Employees Plan	$104	$218	$182	$296
Group Health Classic	74	158	130	214
Group Health Value	20	50	35	65
Kaiser Permanente Classic	101	212	177	288
Kaiser Permanente Value	59	128	103	172
Uniform Medical Plan	28	66	49	87
*or qualified domestic partner				

PEBB does not allow dual health insurance coverage.

If you and your spouse or qualified domestic partner are both eligible for PEBB coverage, you need to decide which of you will cover any eligible children on your medical and/or dental plan. An enrolled family member may be listed on one account, but not both. This also means you could waive the medical coverage on your account and enroll on your spouse's or qualified domestic partner's account.

Selecting the Best Medical Plan for You and Your Family

All medical plans offer the same basic benefits, although benefit enhancements, limitations, premiums, annual deductibles, copays, coinsurance, and out-of-pocket maximums may vary. For example, value plans have lower monthly premiums, but they also have annual deductibles and higher copays for office visits. Only you can decide which plan makes the most sense for you and your family.

Keep in mind: If you cover eligible dependents, they must be covered under the same medical and dental plan you choose.

As you review the plans, here are some things to consider:

- **Geography.** In most cases, you must live in the plan's service area to join the plan. See "Medical Plans Available by County" on pages 20-22. Be sure to contact the plan(s) you're interested in to ask about provider availability in your county.
- **Cost.** Premiums vary by plan. Keep in mind, higher cost doesn't necessarily mean higher quality of care or better benefits; each plan has the same basic level of benefits. The Public Employees Benefits Board sets the premiums for state agency and higher-education employees, based on funding from the Legislature. **If you are employed by a school district, city, county, port, water district, hospital, or other employer group, contact your payroll, personnel, or benefits office to get your monthly premiums.**
- **Special medical needs**. If you or a dependent needs certain medical care, you may want to choose a plan that provides the optimum benefits and coverage for the needed treatment, medications, or equipment. **Please note:** Each plan has a different formulary, which is a list of approved prescription drugs the plan will cover.
- **Coinsurance vs. copays.** The Aetna Public Employees Plan and PEBB's classic and value managed-care plans require you to pay a fixed portion (called a "copay" or "copayment") and/or a coinsurance (percentage of an allowed fee) when you receive network care. UMP requires you to pay a coinsurance.
- **Deductible.** Value managed-care plans and UMP require you to pay an annual deductible before the plan pays for covered services. The UMP also has a separate annual deductible for prescription drugs. Preventive care and certain other benefits are exempt from the UMP medical/ surgical deductible and the value plans' deductibles.
- **Out-of-pocket maximum.** This is the maximum amount you pay in one calendar year. Once you have paid this amount, most plans pay 100 percent of allowed charges for a majority of covered services for the remainder of the calendar year. The out-of-pocket maximum varies by plan. Deductibles are not applied toward your out-of- pocket maximum.
- **Referral procedures.** Some plans allow you to self-refer to any network provider; others require you to have a referral from your primary care provider. All plans allow self-referral to a participating provider for women's health care services.
- **Your provider.** If you have a long-term relationship with your doctor or health-care provider, you should verify whether he or she is a primary care provider in the plan's network before you join by calling the plan directly.
- **Paperwork**. In general, PEBB plans don't require you to file claims. However, UMP members may need to file a claim if they receive services from a provider outside of UMP's network.
- **Coordination with your other benefits.** See "Coordination of Benefits" information on page 10.

Questions? Contact the medical plans directly (phone numbers are listed on the inside front cover).

Want more help making a medical plan choice?

Go to the PEBB's Web site at **www.pebb.hca.wa.gov** to find providers and visit the medical plans' Web sites.

Blue ink indicates information only for subscribers who have dental coverage.

2008 Medical Plans Available by County

Washington

Adams
- Aetna Public Employees Plan
- Uniform Medical Plan

Asotin
- Aetna Public Employees Plan
- Uniform Medical Plan

Benton
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Chelan
- Aetna Public Employees Plan
- Uniform Medical Plan

Clallam
- Aetna Public Employees Plan
- Uniform Medical Plan

Clark
- Aetna Public Employees Plan
- Kaiser Permanente Classic
- Kaiser Permanente Value
- Uniform Medical Plan

Columbia
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Cowlitz
- Aetna Public Employees Plan
- Kaiser Permanente Classic
- Kaiser Permanente Value
- Uniform Medical Plan

Douglas
- Aetna Public Employees Plan
- Uniform Medical Plan

Ferry
- Aetna Public Employees Plan
- Uniform Medical Plan

Franklin
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Garfield
- Aetna Public Employees Plan
- Uniform Medical Plan

Grant
- Aetna Public Employees Plan
- Uniform Medical Plan

Grays Harbor
- Aetna Public Employees Plan
- Group Health Classic (ZIP Codes 98541, 98557, 98559, and 98568)
- Group Health Value (ZIP Codes 98541, 98557, 98559, and 98568)
- Uniform Medical Plan

Island
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Jefferson
- Aetna Public Employees Plan
- Uniform Medical Plan

King
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Kitsap
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Kittitas
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Klickitat
- Aetna Public Employees Plan
- Uniform Medical Plan

Lewis
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Kaiser Permanente Classic (ZIP Codes 98591, 98593, and 98596)
- Kaiser Permanente Value (ZIP Codes 98591, 98593, and 98596)
- Uniform Medical Plan

Lincoln
- Aetna Public Employees Plan
- Group Health Classic (ZIP Codes 99008, 99029, 99032, and 99122)
- Group Health Value (ZIP Codes 99008, 99029, 99032, and 99122)
- Uniform Medical Plan

Mason
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Okanogan
- Aetna Public Employees Plan
- Uniform Medical Plan

Pacific
- Aetna Public Employees Plan
- Uniform Medical Plan

(continued on next page)

In most cases, you must live in the plan's service area to join the plan.
Be sure to call the plan(s) you're interested in to ask about provider availability in your county.

Blue ink indicates information only for subscribers who have dental coverage.

2008 Medical Plans Available by County

Pend Oreille
- Aetna Public Employees Plan
- Group Health Classic (ZIP Code 99009)
- Group Health Value (ZIP code 99009)
- Uniform Medical Plan

Pierce
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

San Juan
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Skagit
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Skamania
- Aetna Public Employees Plan
- Kaiser Permanente Classic (ZIP Codes 98639 and 98648)
- Kaiser Permanente Value (ZIP Codes 98639 and 98648)
- Uniform Medical Plan

Snohomish
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Spokane
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Stevens
- Aetna Public Employees Plan
- Group Health Classic (ZIP Codes 99006, 99013, 99026, 99034, 99040, 99110, 99148, and 99173)
- Group Health Value (ZIP Codes 99006, 99013, 99026, 99034, 99040, 99110, 99148, and 99173)
- Uniform Medical Plan

Thurston
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Wahkiakum
- Aetna Public Employees Plan
- Kaiser Permanente Classic (ZIP Codes 98612 and 98647)
- Kaiser Permanente Value (ZIP Codes 98612 and 98647)
- Uniform Medical Plan

Walla Walla
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Whatcom
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Whitman
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Yakima
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Oregon

Benton
- Aetna Public Employees Plan
- Kaiser Permanente Classic (ZIP Codes 97330, 97331, 97333, 97339, and 97370)
- Kaiser Permanente Value (ZIP Codes 97330, 97331, 97333, 97339, and 97370)
- Uniform Medical Plan

Clackamas
- Aetna Public Employees Plan
- Kaiser Permanente Classic (ZIP Codes 97004, 97009, 97011, 97013, 97015, 97017, 97022-23, 97027, 97034-36, 97038, 97042, 97045, 97049, 97055, 97067-68, 97070, 97089, 97222, 97267, and 97268)
- Kaiser Permanente Value (ZIP Codes 97004, 97009, 97011, 97013, 97015, 97017, 97022-23, 97027, 97034-36, 97038, 97042, 97045, 97049, 97055, 97067-68, 97070, 97089, 97222, 97267, and 97268)
- Uniform Medical Plan

Columbia
- Aetna Public Employees Plan
- Kaiser Permanente Classic
- Kaiser Permanente Value
- Uniform Medical Plan

Hood River
- Aetna Public Employees Plan
- Kaiser Permanente Classic (ZIP Code 97014)
- Kaiser Permanente Value (ZIP Code 97014)
- Uniform Medical Plan

Lane
- Aetna Public Employees Plan
- Uniform Medical Plan

Blue ink indicates information only for subscribers who have dental coverage.

Linn
- Aetna Public Employees Plan
- Kaiser Permanente Classic (ZIP Codes 97321–22, 97335, 97355, 97358, 97360, 97374, and 97389)
- Kaiser Permanente Value (ZIP Codes 97321–22, 97335, 97355, 97358, 97360, 97374, and 97389)
- Uniform Medical Plan

Marion
- Aetna Public Employees Plan
- Kaiser Permanente Classic (ZIP Codes 97002, 97020, 97026, 97032, 97071, 97137, 97301-03, 97305-14, 97317, 97325, 97342, 97346, 97352, 97362, 97373, 97375, 97381, 97383-85, and 97392)
- Kaiser Permanente Value (ZIP Codes 97002, 97020, 97026, 97032, 97071, 97137, 97301-03, 97305-14, 97317, 97325, 97342, 97346, 97352, 97362, 97373, 97375, 97381, 97383-85, and 97392)
- Uniform Medical Plan

Multnomah
- Aetna Public Employees Plan
- Kaiser Permanente Classic
- Kaiser Permanente Value
- Uniform Medical Plan

Polk
- Aetna Public Employees Plan
- Kaiser Permanente Classic
- Kaiser Permanente Value
- Uniform Medical Plan

Umatilla
- Aetna Public Employees Plan
- Group Health Classic (ZIP Codes 97810, 97813, 97835, 97862, 97882, and 97886)
- Group Health Value (ZIP Codes 97810, 97813, 97835, 97862, 97882, and 97886)
- Uniform Medical Plan

Washington
- Aetna Public Employees Plan
- Kaiser Permanente Classic
- Kaiser Permanente Value
- Uniform Medical Plan

Yamhill
- Aetna Public Employees Plan
- Kaiser Permanente Classic
- Kaiser Permanente Value
- Uniform Medical Plan

Idaho

Kootenai
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Latah
- Aetna Public Employees Plan
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

In most cases, you must live in the plan's service area to join the plan.
Be sure to call the plan(s) you're interested in to ask about provider availability in your county.

2008 Medical Benefits Cost Comparison

The following table briefly compares the costs of in-network benefits for the Aetna Public Employees Plan, the PEBB classic and value managed-care plans, and network benefits for the Uniform Medical Plan (UMP). Benefit costs and plan payments are per calendar year, unless otherwise noted. **Call the plans directly for more information on specific benefits or exclusions.**

Benefits for:	*Aetna Public Employees Plan*	CLASSIC MANAGED-CARE PLANS: *Group Health Classic* *Kaiser Permanente Classic*	VALUE MANAGED-CARE PLANS: *Group Health Value* *Kaiser Permanente Value*	PREFERRED PROVIDER ORGANIZATION: *Uniform Medical Plan*
Lifetime maximum	None	None	None	None
Annual deductible	None	None	**Medical services:** Enrollee pays $100 per person/ $300 per family Annual deductible does not apply to some benefits. **Prescription drugs:** None	**Medical services:** Enrollee pays $200 per person/ $600 per family (three or more people) Annual deductible does not apply to some benefits. **Brand-name prescription drug deductible:** Applies to Tier 2 and Tier 3 drugs only; enrollee pays $100 per person/ $300 per family (three or more people)
Annual out-of-pocket maximum	Enrollee pays $750 per person/ $1,500 per family (Expenses as defined in the *Certificate of Coverage* **do not count** toward the out-of-pocket maximum.)	Enrollee pays $750 per person/ $1,500 per family (Expenses as defined in the *Certificate of Coverage* **do not count** toward the out-of-pocket maximum.)	Enrollee pays $1,500 per person/ $3,000 per family (Expenses as defined in the *Certificate of Coverage* **do not count** toward the out-of-pocket maximum.)	Enrollee pays $1,500 per person/ $3,000 per family (Expenses as defined in the *Certificate of Coverage* **do not count** toward the out-of-pocket maximum.)

Blue ink indicates information only for subscribers who have dental coverage.

Benefits for:	*Aetna Public Employees Plan*	CLASSIC MANAGED-CARE PLANS: *Group Health Classic* *Kaiser Permanente Classic*	VALUE MANAGED-CARE PLANS: *Group Health Value* *Kaiser Permanente Value*	PREFERRED PROVIDER ORGANIZATION: *Uniform Medical Plan*
Office and clinic visits	$10 copay per visit	$10 copay per visit	***Group Health,*** $15 copay per visit ***Kaiser Permanente,*** $20 copay per visit	Enrollee pays 10% coinsurance
Ambulance	**Air:** $100 copay per trip **Ground:** $75 copay per trip	**Air:** ***Group Health,*** $100 copay per trip ***Kaiser Permanente,*** $75 copay per trip **Ground:** $75 copay per trip	**Air:** ***Group Health,*** $100 copay per trip ***Kaiser Permanente,*** Enrollee pays 10% coinsurance **Ground:** ***Group Health,*** $75 copay per trip ***Kaiser Permanente,*** Enrollee pays 10% coinsurance	**Air:** Enrollee pays 20% coinsurance **Ground:** Enrollee pays 20% coinsurance
Bariatric surgery	Must be accepted into presurgical program; can only use plan-designated providers. Covered at same level as for other professional services, inpatient/ outpatient hospital services, and tests.	Must be accepted into presurgical program; can only use plan-designated providers. Covered at same level as inpatient/ outpatient and office/clinic visits; preauthorization required.	Must be accepted into presurgical program; can only use plan-designated providers. Covered at same level as inpatient/ outpatient and office/clinic visits; preauthorization required.	Must be accepted into presurgical program; can only use plan-designated providers. Covered at same level as for other professional services, inpatient/ outpatient hospital services, and tests.

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2008 Medical Benefits Cost Comparison

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Benefits for:	***Aetna Public Employees Plan***	**CLASSIC MANAGED-CARE PLANS:** ***Group Health Classic*** ***Kaiser Permanente Classic***	**VALUE MANAGED-CARE PLANS:** ***Group Health Value*** ***Kaiser Permanente Value***	**PREFERRED PROVIDER ORGANIZATION:** ***Uniform Medical Plan***
Chemical dependency services (Maximum payment for all plans is $14,000 per 24 consecutive calendar month period for any combination of inpatient/outpatient treatment)	**Inpatient:** Enrollee pays inpatient hospital copay; preauthorization required **Outpatient:** No copay	**Inpatient:** Enrollee pays inpatient hospital copay **Outpatient:** $10 copay per treatment	**Inpatient:** ***Group Health,*** Enrollee pays inpatient hospital copay ***Kaiser Permanente***, Enrollee pays 10% coinsurance **Outpatient:** ***Group Health,*** $15 copay per treatment ***Kaiser Permanente,*** $20 copay per treatment	**Inpatient Facility:** Enrollee pays inpatient hospital copay **Professional services:** Enrollee pays 10% coinsurance **Outpatient:** Enrollee pays 10% coinsurance
Diabetic education	$10 copay per visit; limited to 10 visits per year, preauthorization required	$10 copay per visit	***Group Health,*** $15 copay per visit ***Kaiser Permanente,*** $20 copay per visit	Enrollee pays 10% coinsurance; up to 10 hours per calendar year (see *Certificate of Coverage* for details).
Diagnostic testing	$10 copay per visit to diagnostic imaging facilities Covered in full if part of an office visit	Covered in full	***Group Health***, Covered in full ***Kaiser Permanente***, Enrollee pays 10% coinsurance	Enrollee pays 10% coinsurance

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Benefits for:	*Aetna Public Employees Plan*	CLASSIC MANAGED-CARE PLANS: *Group Health Classic* *Kaiser Permanente Classic*	VALUE MANAGED-CARE PLANS: *Group Health Value* *Kaiser Permanente Value*	PREFERRED PROVIDER ORGANIZATION: *Uniform Medical Plan*
Durable medical equipment, supplies, and prosthesis	Enrollee pays 20% coinsurance	Enrollee pays 20% coinsurance	Enrollee pays 20% coinsurance (not subject to annual deductible)	Enrollee pays 10% coinsurance; preauthorization required for equipment rentals beyond three months and rentals or purchases of more than $1,000
Emergency room services (Enrollee's ER costs waived by all plans if admitted directly to hospital)	$75 copay per visit	$75 copay per visit	***Group Health,*** $75 copay per visit ***Kaiser Permanente,*** $100 copay per visit	$75 copay per visit, then enrollee pays 10% coinsurance for physician and other professional provider fees
Hearing (examination and hardware)	**Examination:** Covered in full under preventive care benefit; one exam per calendar year **Hardware:** Maximum plan payment of $400 every three calendar years for hearing aid, and rental/repair combined	**Examination:** $10 copay per exam **Hardware:** $300 maximum plan payment every 36 consecutive months for hearing aid and rental/repair when authorized	**Examination:** ***Group Health,*** $15 copay per exam ***Kaiser Permanente,*** $20 copay per exam **Hardware:** $300 maximum plan payment every 36 consecutive months for hearing aid and rental/repair when authorized	**Examination:** Hearing exam covered in full under preventive care benefit; one exam per calendar year **Hardware:** Maximum plan payment of $400 every three calendar years for hearing aid, and rental/repair combined
Home health care	Covered in full	Covered in full	***Group Health,*** Covered in full ***Kaiser Permanente***, Enrollee pays 10% coinsurance	Enrollee pays 10% coinsurance

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2008 Medical Benefits Cost Comparison

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Benefits for:	***Aetna Public Employees Plan***	**CLASSIC MANAGED-CARE PLANS:** ***Group Health Classic*** ***Kaiser Permanente Classic***	**VALUE MANAGED-CARE PLANS:** ***Group Health Value*** ***Kaiser Permanente Value***	**PREFERRED PROVIDER ORGANIZATION:** ***Uniform Medical Plan***
Hospice care (including respite care)	Covered in full; respite care is limited to five days per three-month period	Covered in full for terminally ill enrollees up to six months	Covered in full for terminally ill enrollees up to six months	If preapproved by plan, covered in full $5,000 lifetime maximum plan payment for respite care
Hospital services	**Inpatient services:** $200 copay per day (maximum $600 per person per calendar year) **Outpatient:** $100 copay for facility fees per surgery or procedure; surgeon, anesthesiologist, etc., covered in full	**Inpatient services:** $200 copay per day (maximum $600 per person per calendar year) **Outpatient:** $100 copay for facility fees per surgery or procedure; surgeon, anesthesiologist, etc., covered in full	**Inpatient services:** ***Group Health,*** $200 copay per day (maximum $600 per person per calendar year) ***Kaiser Permanente,*** Enrollee pays 10% coinsurance **Outpatient:** ***Group Health,*** $150 copay for facility fees per surgery or procedure; surgeon, anesthesiologist, etc., covered in full ***Kaiser Permanente,*** Enrollee pays 10% coinsurance	**Inpatient services:** $200 copay per day (maximum $600 per person per calendar year), plus 10% coinsurance for professional services **Outpatient:** Enrollee pays 10% coinsurance
Massage therapy	$10 copay per visit; up to 16 visits per calendar year	Included in physical, occupational, and speech therapy benefit	Included in physical, occupational, and speech therapy benefit	Enrollee pays 10% coinsurance, up to 16 visits per calendar year

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Benefits for:	*Aetna Public Employees Plan*	CLASSIC MANAGED-CARE PLANS: *Group Health Classic* *Kaiser Permanente Classic*	VALUE MANAGED-CARE PLANS: *Group Health Value* *Kaiser Permanente Value*	PREFERRED PROVIDER ORGANIZATION: *Uniform Medical Plan*
Mental health care	**Inpatient:** Enrollee pays inpatient hospital copay; preauthorization required **Outpatient:** $10 copay per visit, up to 50 visits per year	**Inpatient:** Enrollee pays inpatient hospital copay **Outpatient:** $10 copay per visit, up to 50 visits per year	**Inpatient:** ***Group Health,*** Enrollee pays inpatient hospital copay ***Kaiser Permanente,*** Enrollee pays 10% coinsurance **Outpatient:** ***Group Health,*** $15 copay per visit, up to 50 visits per year ***Kaiser Permanente,*** $20 copay per visit, up to 50 visits per year	**Inpatient: Facility—** Enrollee pays inpatient hospital copay; preauthorization required **Professional services—** Enrollee pays 10% coinsurance **Outpatient:** Enrollee pays 10% coinsurance per visit, up to 50 visits per year
Neuro-developmental therapies	Included in physical, occupational, and speech therapy benefit	**Inpatient age 6 and under:** Enrollee pays inpatient hospital copay, up to 60 days per year **Outpatient age 6 and under:** $10 copay per visit, up to 60 visits per year for all therapies combined	**Inpatient age 6 and under:** Enrollee pays inpatient hospital copay, up to 60 days per year **Outpatient age 6 and under:** ***Group Health,*** $15 copay per visit ***Kaiser Permanente,*** $20 copay per visit, up to 60 visits per year for all therapies combined	Included in physical, occupational, and speech therapy benefit

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2008 Medical Benefits Cost Comparison

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Benefits for:	***Aetna Public Employees Plan***	**CLASSIC MANAGED-CARE PLANS:** ***Group Health Classic*** ***Kaiser Permanente Classic***	**VALUE MANAGED-CARE PLANS:** ***Group Health Value*** ***Kaiser Permanente Value***	**PREFERRED PROVIDER ORGANIZATION:** ***Uniform Medical Plan***
Obstetric and well-newborn care	**Inpatient:** Enrollee pays inpatient hospital copay for mother only **Professional services:** Covered in full after $10 copay for first visit	**Inpatient:** Enrollee pays inpatient hospital copay for mother only **Professional services:** Covered in full	**Inpatient:** Enrollee pays inpatient hospital copay for mother only **Professional services:** Covered in full	**Inpatient:** Enrollee pays inpatient hospital copay for mother only **Professional services:** Enrollee pays 10% coinsurance
Organ transplants	**Facility:** Enrollee pays inpatient hospital copay; preauthorization required **Professional services:** Covered in full; preauthorization required No limit on number of donor searches	**Facility:** Enrollee pays inpatient hospital copay; preauthorization required **Professional services:** Covered in full; preauthorization required Bone marrow donor searches covered in full, up to 15 searches per person per transplant	**Facility:** Enrollee pays inpatient hospital copay; preauthorization required **Professional services:** Covered in full; preauthorization required Bone marrow donor searches covered in full, up to 15 searches per person per transplant	**Facility:** Enrollee pays inpatient hospital copay; preauthorization required **Professional services:** Enrollee pays 10% coinsurance Enrollee pays 10% coinsurance for donor searches; no limit on number of searches

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Benefits for:	*Aetna Public Employees Plan*	CLASSIC MANAGED-CARE PLANS: *Group Health Classic* *Kaiser Permanente Classic*	VALUE MANAGED-CARE PLANS: *Group Health Value* *Kaiser Permanente Value*	PREFERRED PROVIDER ORGANIZATION: *Uniform Medical Plan*
Physical, occupational and speech therapy	Does not include massage therapy (see massage therapy benefit) Includes neurodevelopmental therapy **Inpatient:** Enrollee pays inpatient hospital copay; preauthorization required **Outpatient:** $10 copay per visit, up to 60 visits per calendar year	**Inpatient:** Enrollee pays inpatient hospital copay, up to 60 days per year Includes massage therapy **Outpatient:** $10 copay per visit, up to 60 visits per year for all therapies combined Includes massage therapy	**Inpatient:** Enrollee pays inpatient hospital copay, up to 60 days per year Includes massage therapy **Outpatient:** ***Group Health,*** $15 copay per visit ***Kaiser Permanente,*** $20 copay per visit, up to 60 visits per year for all therapies combined Includes massage therapy	Does not include massage therapy (see massage therapy benefit) Includes neuro-developmental therapy **Inpatient:** Enrollee pays inpatient hospital copay; preauthorization required **Outpatient:** Enrollee pays 10% coinsurance per visit, up to 60 visits per calendar year

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2008 Medical Benefits Cost Comparison

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Benefits for:	*Aetna Public Employees Plan*	CLASSIC MANAGED-CARE PLANS: *Group Health Classic* *Kaiser Permanente Classic*	VALUE MANAGED-CARE PLANS: *Group Health Value* *Kaiser Permanente Value*	PREFERRED PROVIDER ORGANIZATION: *Uniform Medical Plan*
Prescription drugs, insulin, and disposable diabetic supplies	**Retail** (up to a 30-day supply): Tier 1 (generic and preferred specialty drugs), $10 copay; Tier 2 (preferred brand), $25 copay; Tier 3* (nonpreferred brand), $40 copay **Mail order** (up to a 90-day supply): Tier 1 (generic and preferred specialty drugs), $20 copay; Tier 2 (preferred brand), $50 copay; Tier 3* (nonpreferred brand), $80 copay **Multi-source Tier 3 drugs are subject to an ancillary charge—the enrollee pays the Tier 1 copay, plus the difference between the Tier 3 drug and the generic equivalent.*	***Group Health Classic*** **Retail** (up to a 30-day supply): Formulary generic, all insulin, and all disposable diabetic supplies, $10 copay; formulary brand-name drugs, $30 copay **Mail order** (up to 90-day supply): Formulary generic, all insulin, and all disposable diabetic supplies, $20 copay; formulary brand-name drugs, $40 copay ***Kaiser Permanente Classic*** **Retail** (up to a one-month supply): Formulary generic, all insulin, and all disposable diabetic supplies, $10 copay; formulary brand-name drugs, $25 copay M**ail order** (up to 90-day supply): Formulary generic, all insulin, and all disposable diabetic supplies, $20 copay; formulary brand-name drugs, $50 copay	***Group Health Value*** **Retail** (up to a 30-day supply): Formulary generic, all insulin, and all disposable diabetic supplies, $10 copay; formulary brand-name drugs, $30 copay **Mail order** (up to 90-day supply): Formulary generic, all insulin, and all disposable diabetic supplies, $20 copay; formulary brand-name drugs, $60 copay ***Kaiser Permanente Value*** **Retail** (up to a one-month supply): Formulary generic, all insulin, and all disposable diabetic supplies, $10 copay; formulary brand-name drugs, $30 copay **Mail order** (up to 90-day supply): Formulary generic, all insulin, and all disposable diabetic supplies, $20 copay; formulary brand-name drugs, $60 copay	Up to a 90-day supply (annual prescription-drug deductible applies only to Tier 2 and Tier 3 drugs) **Retail:** Tier 1 (generic and preferred specialty drugs), 10% enrollee coinsurance; Tier 2 (preferred brand), 30% enrollee coinsurance Tier 3* (nonpreferred brand) 50% enrollee coinsurance Note: Tier 1 and 2 drugs purchased through a network retail pharmacy have a maximum enrollee cost share of $75 (per 30-day supply). **Mail order:** Tier 1, $10 copay; Tier 2, $50 copay; Tier 3*, $100 copay **Multi-source Tier 3 drugs are subject to an ancillary charge—the enrollee pays the Tier 1 copay, plus the difference between the Tier 3 drug and the generic equivalent.*

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Benefits for:	*Aetna Public Employees Plan*	CLASSIC MANAGED-CARE PLANS: *Group Health Classic* *Kaiser Permanente Classic*	VALUE MANAGED-CARE PLANS: *Group Health Value* *Kaiser Permanente Value*	PREFERRED PROVIDER ORGANIZATION: *Uniform Medical Plan*
Preventive care	Covered in full, subject to preventive care schedule Only services listed in the *Certificate of Coverage* are covered as preventive care.	Covered in full, subject to plan schedule	Covered in full, subject to plan schedule (not subject to annual deductible)	Covered in full, subject to preventive care schedule (not subject to annual medical deductible) Only services listed in the *Certificate of Coverage* are covered as preventive care.
Radiation and chemotherapy services	$10 copay per visit	Covered in full	Covered in full	Enrollee pays 10% coinsurance
Skilled nursing facility care	Enrollee pays inpatient hospital copay; covered up to 150 days per calendar year	Enrollee pays inpatient hospital copay, covered up to 150 days per year (additional coverage may be approved if it substitutes for hospitalization)	Enrollee pays inpatient hospital copay or coinsurance, covered up to 150 days per year (additional coverage may be approved if it substitutes for hospitalization)	Enrollee pays inpatient hospital copay; covered up to 150 days per calendar year
Spinal manipulations	$10 copay per visit, up to 10 visits per year	$10 copay per visit, up to 10 self-referred visits per year; preauthorization required for more than 10 visits	***Group Health,*** $15 copay per visit, up to 10 self-referred visits per year; preauthorization required for more than 10 visits ***Kaiser Permanente,*** $20 copay per visit, up to 10 visits per year; preauthorization required for more than 10 visits (not subject to annual deductible)	Enrollee pays 10% coinsurance, up to 10 visits per year

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2008 Medical Benefits Cost Comparison

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Benefits for:	*Aetna Public Employees Plan*	CLASSIC MANAGED-CARE PLANS: *Group Health Classic* *Kaiser Permanente Classic*	VALUE MANAGED-CARE PLANS: *Group Health Value* *Kaiser Permanente Value*	PREFERRED PROVIDER ORGANIZATION: *Uniform Medical Plan*
Temporo-mandibular joint (TMJ) disorder	Preauthorized surgical treatment only—enrollee pays inpatient or outpatient copay **Non-surgical treatment for TMJ is not covered.**	Enrollee pays 50% coinsurance for inpatient and outpatient treatment, maximum plan payment of $1,000 per year (orthognathic surgery not covered)	Enrollee pays 50% coinsurance for inpatient and outpatient treatment, maximum plan payment of $1,000 per year (orthognathic surgery not covered)	Preauthorized surgical treatment only—enrollee pays inpatient hospital copay and 10% of professional provider fees (orthognathic surgery not covered) **Non-surgical treatment for TMJ is not covered.**
Vision	**Examination:** $10 copay per exam; one annual eye exam **Hardware:** $150 maximum plan payment every two calendar years for frames, lenses, contacts, and fitting fees combined	**Examination:** $10 copay per exam; one annual eye exam **Hardware:** $150 maximum plan payment once every two calendar years for frames, lenses, contacts, and fitting fees combined	**Examination:** ***Group Health,*** $15 copay per exam; one annual eye exam ***Kaiser Permanente,*** $20 copay per exam; one annual eye exam **Hardware:** $150 maximum plan payment every two calendar years for frames, lenses, contacts, and fitting fees combined (not subject to annual deductible)	**Examination:** Enrollee pays 10% coinsurance; one annual eye exam (not subject to annual medical deductible) **Hardware:** $150 maximum plan payment every two calendar years for frames, lenses, contacts, and fitting fees combined (not subject to annual medical deductible)
Well-baby care	Covered in full; subject to preventive care schedule	Covered in full; subject to plan schedule	Covered in full; subject to plan schedule	Covered in full; subject to preventive care schedule (not subject to annual medical deductible)

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General Medical Exclusions

Expenses Not Covered, Exclusions, and Limitations

What Aetna Public Employees Plan Doesn't Cover:

Aetna Public Employees Plan covers only the services and conditions specifically identified in this Certificate of Coverage. Unless a service or condition fits into one of the specific benefit definitions, it is not covered. If you have questions, call Member Services at 1-800-222-9205.

Here are some examples of common services and conditions that are not covered. Many others are also not covered—these are examples only, not a complete list. These examples are called exclusions, meaning these services are not covered, even if medically necessary.

1. Acupuncture, except as described under "Acupuncture."
2. Air ambulance, if ground ambulance would serve the same purpose.
3. Carotid Intima Thickness Testing.
4. Circumcision, unless determined medically necessary for a medical condition.
5. Complications directly arising from services that are not covered.
6. Conditions caused by or arising from acts of war.
7. Cosmetic services or supplies, including drugs, pharmaceuticals, removal of excess tissue, and similar procedures. However, Aetna Public Employees Plan does cover:
   - Reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
   - Reconstructive surgery of a congenital anomaly (such as cleft lip or palate).
8. Court-ordered care, unless determined by Aetna Public Employees Plan to be medically necessary and otherwise covered.
9. Custodial care.
10. Dental care for the treatment of problems with teeth or gums, other than the specific covered dental services listed under "Dental Services."
11. Dietary or food supplements, including:
    - Herbal supplements, dietary supplements, medicinal foods, and homeopathic drugs.
    - Infant or adult dietary formulas, except for treatment of congenital metabolic disorders such as phenylketonuria (PKU) detected by newborn screening, when specialized formulas have been established as effective for treatment.
    - Minerals.
    - Prescription or over-the-counter vitamins (except prenatal vitamins during pregnancy).
12. Dietary programs designed for weight control or weight loss.
13. Drugs or medicines not covered by Washington State Rx Services as described in "Your Prescription Drug Benefit" section.
14. Educational programs, except those listed under "Diabetes Education" and "Tobacco Cessation Program."
15. Electron Beam Tomography (EBT), self-referred or prescribed by a provider.
16. Equipment not primarily intended to improve a medical condition or injury, including but not limited to:
    - Air conditioners or air purifying systems.
    - Arch supports.
    - Communication aids.
    - Elevators.
    - Exercise equipment.
    - Massage devices.
    - Overbed tables.
    - Sanitary supplies.
    - Telephone alert systems.
    - Vision aids.
    - Whirlpools, portable whirlpool pumps, or sauna baths.
17. Erectile or sexual dysfunction treatment with drugs or pharmaceuticals.
18. Experimental or investigational services, supplies, or drugs, except for clinical trials consistent with Medicare coverage criteria.

Call the plans directly for more information on specific benefits or exclusions.

General Medical Exclusions

19. Extracorporeal Shockwave Therapy (low-energy shock waves focused on a source of pain such as soft tissue).
20. Eye surgery to alter the refractive character of the cornea, such as radial keratotomy, photokeratectomy, or LASIK surgery.
21. Foot care: Cutting of toenails; non-surgical care for diagnosed corns and calluses; or any other routine foot care (unless you are diabetic).
22. Genetic testing done solely to select a medication to treat a new diagnosis.
23. Genetic testing or counseling for family planning, or any other genetic testing or counseling, except as described under "Genetic Counseling and Testing."
24. Home health care except as provided under "Home Health Care." For example, Aetna Public Employees Plan does not cover the following:
    - Any services or supplies not included in the home health care treatment plan or not specifically mentioned under the "Home Health Care" section.
    - Dietary assistance.
    - Expenses related to normal activities of living such as food, clothing, household supplies, Meals on Wheels, or similar services.
    - Homemaker, chore worker, or housekeeping services.
    - Custodial care.
    - Nonclinical social services.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Services that are not medically necessary.
25. Hospice care except as provided under "Hospice Care (Including Respite Care)." For example, the following are not covered:
    - Any services or supplies not included in the hospice care plan, or not specifically mentioned under the "Hospice Care" section.
    - Expenses related to normal activities of living such as food, clothing, household supplies, Meals on Wheels, or similar services.
    - Homemaker, chore worker, or housekeeping services (except as provided by home health aides as part of the hospice program).
    - Legal or financial counseling.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Services provided while the member is receiving home health care benefits.
    - Services to other than the terminally ill member including bereavement, pastoral, or spiritual counseling.
26. Hospital inpatient charges such as admissions solely for diagnostic procedures that could be performed on an outpatient basis.
27. Immunizations, except as described under "Preventive Care." Immunizations for the purpose of travel or employment, or required because of where you reside, or any other reasons not listed, are not covered.
28. In vitro fertilization and all related services and supplies, including all procedures involving selection of embryo for implantation.
29. Learning disabilities treatment after diagnosis, except as described under "Physical, Occupational, Speech, and Neurodevelopmental Therapy," or when treatment is part of a mental health disorder and covered under "Mental Health."
30. Magnetic Resonance Imaging—Upright MRIs (uMRI), also known as "positional," "weight-bearing" (partial or full), or "axial loading."
31. Maintenance therapy.
32. Manipulations of the spine or extremities, except as described under "Spinal and Extremity Manipulations."
33. Massage therapy, unless services meet the criteria in "Massage Therapy."
34. Medicare-covered services or supplies delivered under a private contract with a provider who does not offer services through Medicare, when Medicare is the patient's primary coverage.
35. Mental health:
    - Inpatient programs not solely for treatment of chemical dependency or a mental health condition that requires inpatient care treatment (examples include, but are not limited to schools, wilderness programs, and behavioral programs for adolescents).
    - Marital, family, or other counseling or training services, except when provided to treat an individual member's neuropsychiatric, mental, or personality disorder.

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36. Missed appointments.
37. Organ donor coverage for anyone who is not an Aetna Public Employees Plan member, or costs of locating a donor (such as tissue typing of family members), except as described under "Organ Transplants."
38. Orthognathic surgery, or surgery to straighten or correct the jaw, except that Aetna Public Employees Plan does cover surgery to treat a congenital anomaly such as cleft lip or palate.
39. Orthoptic therapy (eye training) or vision services, except as described under "Vision Care (Routine)."
40. Orthotics (except for diabetics; see "Durable Medical Equipment, Supplies, and Prostheses").
41. Other insurance coverage—Services or supplies are not covered if benefits are available under any automobile medical, automobile no-fault, personal injury protection, commercial liability, commercial premises medical, homeowner's policy, or other similar type of insurance or contract, if it covers medical treatment of injuries. (When we say "available," we mean that you could get services paid under another policy by making a claim.) However, Aetna Public Employees Plan may advance payments to you (except for workers' compensation claims, which are not covered; see exclusion #62) with the expectation that Aetna Public Employees Plan will be reimbursed from any settlement.
42. Panniculectomy or removal of excess skin due to weight loss.
43. Physical exam—Any additional portion of a physical exam beyond what Aetna Public Employees Plan covers under the preventive care benefit, even if required for employment, travel, immigration, licensing, or insurance and related reports.
44. Provider administrative fees—Any charges for completing forms or copying records, except for records requested by Aetna Public Employees Plan to perform retrospective utilization review.
45. Recreation therapy.
46. Replacement of lost or stolen durable medical equipment.
47. Replacement of lost or stolen medications or medications confiscated or seized by Customs or other authorities.
48. Reproductive failure or sterility testing or treatment, including drugs, pharmaceuticals, artificial insemination, and any other type of testing or treatment.
49. Residential treatment programs that are not solely for chemical dependency treatment or a mental health condition requiring inpatient care treatment (such as schools, wilderness programs, and behavioral programs for teenagers).
50. Reversal of voluntary sterilization (vasectomy or tubal ligation).
51. Services provided by non-network providers, except for emergency care.
52. Services provided by an Aetna network provider or obtained without following Aetna's standard precertification requirements.
53. Services or supplies:
    - That are not medically necessary, as determined by the plan, for the diagnosis and treatment of illness, injury, or restoration of physiological functions, and are not covered as preventive care. This applies even if services are prescribed, recommended or approved by your provider.
    - For which no charge is made, or for which a charge would not have been made if you had no health care coverage.
    - Provided by a family member or any household member.
    - Provided by a resident physician or intern acting in that capacity.
    - That are solely for comfort (except as described in "Hospice Care").
    - For which you are not obligated to pay.
54. Sexual dysfunction or disorder diagnosis, counseling or treatment (except for penile prostheses, as stated under "Durable Medical Equipment, Supplies, and Prostheses").
55. Sexual reassignment surgery, services, counseling, or supplies.
56. Skilled nursing facility services or confinement:
    - For treatment of mental health conditions or mental retardation.
    - When primary use of the facility is as a place of residence.
    - When treatment is primarily custodial.

General Medical Exclusions

57. Temporomandibular joint (TMJ) disorder treatment, except as described under "Temporomandibular Joint (TMJ) Treatment."
58. Tobacco cessation services, supplies, or medications, except as described under "Tobacco Cessation Program."
59. Transportation by "cabulance" or other nonemergency service.
60. Weight control, weight loss, and obesity treatment:

    Non-surgical: Any program, drugs, services, or supplies for weight control, weight loss, or obesity treatment. Exercise programs (formal or informal), exercise equipment, or travel expenses associated with non-surgical or surgical services are not covered. Such treatment is not covered even if prescribed by a provider.

    Surgical: Any bariatric surgery procedure, any other surgery for obesity or morbid obesity, and any related medical services, drugs, or supplies, except if approved through case management as described under "Obesity Surgery." Removal of excess skin is not covered.
61. Wilderness training programs.
62. Workers' compensation—Aetna Public Employees Plan does not cover services or supplies if benefits are available under any workers' compensation or other similar type of program, insurance, or contract. (When we say "available," we mean that you could get services paid for by a workers' compensation or similar program by making a claim.)

    If you have questions about whether a certain service or supply is covered, call Aetna Public Employees Plan at 1-800-222-9205.

What the Managed-Care Plans Don't Cover:

The following services and supplies are excluded from all PEBB-sponsored managed-care plans. Plan-specific exceptions are noted. For further explanation of any exclusion, refer to the plan's certificate of coverage.

1. Services not provided by a plan-designated provider or obtained in accordance with the plan's standard referral and authorization requirements, except for emergency care or as covered under coordination of benefits provisions.
2. Non-participating providers are not covered inside or outside of the service area except for: emergencies; as specifically provided in the student eligibility section; or when otherwise specifically provided.
3. Experimental or investigational services, supplies, and drugs.
4. That additional portion of a physical exam beyond a routine physical that is specifically required for the purpose of employment, travel, immigration, licensing, or insurance and related reports.
5. Services or supplies for which no charge is made, or for which a charge would not have been made if the enrollee had no health care coverage or for which the enrollee is not liable; services provided by a family member.
6. Drugs and medicines not prescribed by a plan-designated provider, except for emergency treatment.
7. Cosmetic services or supplies except: to restore function, for reconstructive surgery of a congenital anomaly, or reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
8. Skilled nursing facility confinement or residential mental health treatment programs for mental health conditions, mental retardation, or for care which is primarily domiciliary, convalescent, or custodial in nature.
9. Conditions caused by or arising from acts of war.
10. Dental care including: orthognathic surgery (except for congenital anomalies), myofascial pain dysfunction (MPD), and dental implants.
11. Sexual reassignment surgery, services, and supplies.
12. Reversal of voluntary sterilization.
13. Testing and treatment of infertility and sterility, including but not limited to artificial insemination and in vitro fertilization.
14. Services and supplies provided solely for the comfort of the enrollee, except palliative care provided under the "Hospice Care" benefit.
15. Coverage for an organ donor, unless the recipient is an enrollee of the plan.
16. Weight control, obesity treatment, and treatment for morbid obesity, including any medical services, drugs, supplies, or any bariatric surgery (such as gastroplasty, gastric banding, or intestinal bypass), regardless of co-morbidities, complications of obesity, or any other medical condition. **Exception:** The surgical exclusion noted above does **not** apply to Group Health Cooperative or Kaiser Permanente pre-authorized, medically necessary bariatric surgery for treatment of

adult morbid obesity as shown in each plan's certificate of coverage and Bariatric Management criteria.

17. Evaluation and treatment of learning disabilities, including dyslexia, except as provided for neurodevelopmental therapies.
18. Orthoptic therapy (eye training); vision services, except as specified for vision care. Surgery to improve the refractive character of the cornea including any direct complications.
19. Orthotics, except foot care appliances for prevention of complications associated with diabetes, which are covered.
20. Routine foot care.
21. Services for which an enrollee has a contractual right to recover cost under homeowner's or other no-fault coverage, to the extent that it can be determined that the enrollee received double recovery for such services.
22. Any medical services or supplies not specifically listed as covered.
23. Direct complications arising from excluded services.
24. Pharmaceutical treatment of impotence or sexual dysfunction.
25. When Medicare coverage is primary, charges for services or supplies provided to enrollees through a "private contract" agreement with a physician or practitioner who does not provide services through the Medicare program.
26. Replacement of lost or stolen medications.
27. Recreation therapy.

What UMP Doesn't Cover:

UMP covers only the services and conditions specifically identified in this Certificate of Coverage. Unless a service or condition fits into one of the specific benefit definitions, it is not covered. If you have questions, call Customer Service at 1-800-762-6004.

Here are some examples of common services and conditions that are **not** covered. Many others are also not covered—these are examples only, not a complete list. These examples are called "exclusions": these services are not covered, ***even if medically necessary***.

1. Acupuncture, except as described under "Acupuncture."
2. Air ambulance, if ground ambulance would serve the same purpose (see also exclusion 62).
3. Carotid Intima Media Thickness testing.
4. Circumcision, unless determined medically necessary for a medical condition.
5. Complications directly arising from services that are not covered.
6. Conditions caused by or arising from acts of war.
7. Cosmetic services or supplies, including drugs, pharmaceuticals, removal of excess tissue and similar procedures. However, UMP does cover:
   - Reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
   - Reconstructive surgery of a congenital anomaly (such as cleft lip or palate).
8. Court-ordered care, unless determined by UMP to be medically necessary and otherwise covered.
9. Custodial care; see in "Definitions" section.
10. Dental care for the treatment of problems with teeth or gums, other than the specific covered dental services listed under "Dental Services."
11. Dietary or food supplements, including:
    - Herbal supplements, dietary supplements, medicinal foods, and homeopathic drugs.
    - Infant or adult dietary formulas, except for treatment of congenital metabolic disorders detected by newborn screening such as phenylketonuria (PKU) when specialized formulas have been established as effective for treatment.
    - Minerals.
    - Prescription or over-the-counter vitamins (except prenatal vitamins during pregnancy).
12. Dietary programs designed for weight control or weight loss.
13. Drugs or medicines not covered by UMP as described in the "How the UMP Prescription Drug Benefit Works" section.
14. Educational programs, except those listed under "Diabetes Education," "Nutritional Therapy," and "Tobacco Cessation Program."
15. Electron Beam Tomography (EBT), self-referred or prescribed by a provider.
16. Equipment not primarily intended to improve a medical condition or injury, including but not limited to:
    - Air conditioners or air purifying systems.

General Medical Exclusions

- Arch supports.
- Exercise equipment.
- Sanitary supplies.

17. Erectile or sexual dysfunction treatment with drugs or pharmaceuticals.
18. Experimental or investigational services, supplies, or drugs, except for clinical trials consistent with Medicare coverage criteria.
19. Extracorporeal Shockwave Therapy; low-energy shock waves focused on a source of pain (soft tissue).
20. Eye surgery to alter the refractive character of the cornea, such as radial keratotomy, photokeratectomy, or LASIK surgery.
21. Foot care: Cutting of toenails; non-surgical care for diagnosed corns and calluses; or any other routine foot care (unless you are diabetic).
22. Genetic testing done solely to select a medication to treat a new diagnosis.
23. Genetic testing or counseling for family planning, or any other genetic testing or counseling, except as described under "Genetic Testing."
24. Home health care except as described under "Home Health Care (Including Respite Care)." For example, UMP does not cover the following home health services:
    - Any services or supplies not included in the home health care treatment plan or not specifically mentioned under "Home Health Care (Including Respite Care)."
    - Unless preauthorized:
      - Daily visits.
      - Visits exceeding two hours per day.
      - Visits continuing for more than three weeks.
      - 24-hour or full-time care in the home.
    - Dietary assistance.
    - Expenses for normal activities of living such as food, clothing, household supplies, Meals on Wheels, or similar services.
    - Homemaker, chore worker, or housekeeping services.
    - Custodial care.
    - Nonclinical social services.
    - Psychiatric care.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Services that are not medically necessary.
25. Hospice care except as provided under "Hospice Care." For example, the following are not covered:
    - Any services or supplies not included in the hospice care plan, not specifically mentioned under "Hospice Care," or provided in excess of the specified limits.
    - Expenses for normal necessities of living such as food, clothing, household supplies, Meals on Wheels, or similar services.
    - Homemaker, chore worker, or housekeeping services (except as provided by home health aides as part of the hospice program).
    - Legal or financial counseling.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Services provided while the enrollee is receiving home health care benefits.
    - Services to other than the terminally ill enrollee including bereavement, pastoral, or spiritual counseling.
26. Hospital inpatient charges such as:
    - Admissions solely for diagnostic procedures that could be performed on an outpatient basis.
    - Beds "reserved" while the patient is being treated in a special-care unit or is on leave from the hospital.
    - High-cost services and devices that do not meet the medical necessity criteria of "the level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention." See additional information under "Hospital Services."
    - Personal items (television, special diets not medically necessary to treat the covered condition, or convenience items).
    - Private room charges, unless medically necessary and preauthorized by UMP.
27. Immunizations, except as described under "Preventive Care." Immunizations for the purpose of travel or employment, or required because of where you reside, are not covered.
28. In vitro fertilization and all related services and supplies, including all procedures involving selection of embryo for implantation.

Blue ink indicates information only for subscribers who have dental coverage.

29. Learning disabilities treatment after diagnosis, except as described under "Physical, Occupational, Speech, and Neurodevelopmental Therapy," or when treatment is part of a mental health disorder and covered under the "Mental Health" benefit.
30. Magnetic Resonance Imaging—Using upright MRIs (uMRI): Also known as "positional," "weight-bearing" (partial or full), or "axial loading."
31. Maintenance therapy (see in "Definitions" section).
32. Manipulations of the spine or extremities, except as described under "Spinal and Extremity Manipulations."
33. Massage therapy, unless services meet the criteria in "Massage Therapy." Also, services from massage therapists who are not UMP network providers, and services not preauthorized that are longer than one hour per session, are not covered.
34. Medicare-covered services or supplies delivered under a "private contract" with a provider who does not offer services through Medicare, when Medicare is the patient's primary coverage.
35. Mental health:
    - Inpatient programs not solely for treatment of chemical dependency or a mental health condition that requires inpatient care treatment (examples include, but are not limited to: schools, wilderness programs, and behavioral programs for adolescents).
    - Marital, family, or other counseling or training services, except when provided to treat neuropsychiatric, mental, or personality disorders (covered services are described under "Mental Health").
    - Services from non-PhD psychologists (unless the provider is employed by and delivers services within a licensed community mental health agency, ***and*** that agency bills for the services).
36. Missed appointments.
37. Non-approved provider types—Services delivered by types of providers not listed as approved under "Approved Provider Types," or by providers delivering services outside of the scope of their licenses, are not covered.
38. Non-network provider charges that are above the UMP allowed amount, even when the provider is paid at the out-of-area rate, except when the enrollee has been admitted to the hospital as a result of an emergency room visit and the annual out-of-pocket limit has been met.
39. Organ donor coverage for anyone who is not a UMP enrollee, or costs of locating a donor (such as tissue typing of family members), except as described under "Organ Transplants."
40. Organ transplant expenses not preauthorized by UMP.
41. Orthognathic surgery, or surgery to straighten or correct the jaw, except that UMP does cover surgery to treat a congenital anomaly (such as cleft lip or palate).
42. Orthoptic therapy (eye training) or vision services, except as described under "Vision Care (Routine)."
43. Orthotics (except for diabetics; see "Durable Medical Equipment, Supplies, and Prostheses").
44. Other insurance coverage—Services or supplies are not covered if benefits are available under any automobile medical, automobile no-fault, personal injury protection, commercial liability, commercial premises medical, homeowner's policy, or other similar type of insurance or contract, if it covers medical treatment of injuries. (When we say "available," we mean that you could get services paid under another policy by making a claim.) However, UMP may advance payments to you with the expectation that UMP will be reimbursed from any settlement—except for workers' compensation claims, which are not covered (see exclusion 65).
45. Panniculectomy or removal of excess skin due to weight loss.
46. Physical exam—Any additional portion of a physical exam beyond what UMP covers under "Preventive Care," even if required for employment, travel, immigration, licensing, or insurance and related reports.
47. Prescription drug charges over the UMP allowed amount, regardless of where purchased.
48. Provider administrative fees—Any charges for completing forms or copying records, except for records requested by UMP to perform retrospective utilization review.
49. Recreation therapy.
50. Registered counselors of any type.
51. Replacement of lost or stolen durable medical equipment.
52. Replacement of lost or stolen medications or medications confiscated or seized by Customs or other authorities.

General Medical Exclusions

53. Reproductive failure or sterility testing or treatment, including drugs, pharmaceuticals, artificial insemination, and any other type of testing or treatment.
54. Residential treatment programs that are not solely for chemical dependency treatment or a mental health condition requiring inpatient care treatment (such as schools, wilderness programs, and behavioral programs for teenagers).
55. Reversal of voluntary sterilization (vasectomy or tubal ligation).
56. Services or supplies:
    - For which no charge is made, or for which a charge would not have been made if you had no health care coverage.
    - Provided by a family member.
    - That are solely for comfort (except as described in "Hospice Care").
    - For which you are not obligated to pay.
57. Sexual dysfunction or disorder diagnosis, counseling, or treatment (except for penile prostheses, as stated under "Durable Medical Equipment, Supplies, and Services").
58. Sexual reassignment surgery, services, counseling, or supplies.
59. Skilled nursing facility services or confinement:
    - For treatment of mental health conditions or mental retardation.
    - When primary use of the facility is as a place of residence.
    - When treatment is primarily custodial (see "Custodial Care" in "Definitions" section).
60. Temporomandibular joint (TMJ) disorder treatment, except as described under "Temporomandibular Joint (TMJ) Treatment."
61. Tobacco cessation services, supplies, or medications, except as described under "Tobacco Cessation Program."
62. Transportation by "cabulance" or other nonemergency service.
63. Weight control, weight loss, and obesity treatment as follows:
    - **Non-surgical:** Any program, drugs, services, or supplies for weight control, weight loss, or obesity treatment. UMP does not cover exercise programs (formal or informal), exercise equipment, or travel expenses associated with non-surgical or surgical services. UMP will not cover such treatment even if prescribed by a provider.
    - **Surgical:** Any bariatric surgery procedure, any other surgery for obesity or morbid obesity, and any related medical services, drugs, or supplies unless approved through case management as described under "Obesity Surgery." Removal of excess skin is not covered.
64. Wilderness training programs.
65. Workers' compensation—UMP does not cover services or supplies if benefits are available under any workers' compensation or other similar type of program, insurance, or contract. (When we say "available," we mean that you could get services paid for under another policy by making a claim.)

If you have questions about whether a certain service or supply is covered, call UMP at 1-800-762-6004 (or 425-670-3000 in the Seattle area).

Blue ink indicates information only for subscribers who have dental coverage.

How the Dental Plans Work

You have three dental plans to choose from:

Preferred Provider Organization (PPO)

- The ***Uniform Dental Plan*** (UDP), a preferred provider plan administered by Washington Dental Service (WDS), allows you the freedom to choose any dentist. However, it provides a higher level of reimbursement if your dentist is a WDS-participating provider. The UDP offers services in every county of Washington State. Outside of Washington, services are reimbursed at a higher level than for services provided by non-PPO dentists in Washington.

  You can verify your dentist's participation by calling Uniform Dental Plan at 1-800-537-3406.

  Note: UDP does **not** issue I.D. cards.

Managed-Care Plans

- Under ***DeltaCare, administered by WDS***, you select a primary care dentist from the DeltaCare network, and you must receive care from your selected dentist. Because WDS administers several dental plans, each with its own provider network, **be sure to verify that your dentist is in the DeltaCare network serving PEBB members.** This is important, as you could be responsible for costs if you receive care from a provider who is not in the DeltaCare network. Providers are located in Arlington*, Auburn, Bellevue, Bellingham, Bonney Lake*, Bothell, Bremerton, Burien, Edmonds, Everett*, Federal Way, Fircrest*, Issaquah, Kennewick, Kent, Lacey, Lakewood*, Lynnwood, Mukilteo*, Newcastle*, Olympia*, Puyallup*, Renton, Seattle, Shelton*, Shoreline, Spokane, Tacoma, Tukwila, Vancouver, Wenatchee, Yakima, and Hillsboro and Portland (Oregon).

  **Not accepting new patients*

- ***Willamette Dental Plan*** requires that you receive care from Willamette Dental dentists or specialists. Their *dental offices are located* in Bellevue, Bellingham, Everett, Federal Way, Kennewick, Kent, Lakewood, Longview, Lynnwood, Olympia, Pullman, Puyallup, Renton, Richland, Seattle, Silverdale, Spokane, Tacoma, Tumwater, Vancouver, Wenatchee, Yakima, and Portland metro area (Oregon).

Note: Since dentist and clinic participation with the dental plans can change, **please contact the dental plans to verify dentists and clinic locations**.

More information on Washington Dental Service

Washington Dental Service (WDS) is a member of the nationwide Delta Dental Plans Association. WDS administers several dental plans, including the Uniform Dental Plan (UDP) and DeltaCare. If you choose UDP or DeltaCare, be sure that you choose a WDS member dentist who participates in your plan's network. Each plan has its own provider network.

Is a Managed-Care Dental Plan Right For You?

The table on the next page briefly compares the features of the UDP and the managed-care dental plans. Before enrolling in a managed-care dental plan, it is important to answer the following questions:

- Is the dentist I have chosen accepting new patients? (Remember to identify yourself as a PEBB member.)
- Am I willing to travel for services if I select a dentist in another service area?
- Do I understand that all dental care is managed through my primary care dentist or network provider, and I cannot self-refer for specialty care?

If your answer to these questions is yes, you may want to consider enrolling in a managed-care dental plan.

For full coverage provisions, including limitations and exclusions, refer to a PEBB certificate of coverage (available through the dental plans).

Note: Benefits for emergency care received out of the plan's service area; missed appointment charges; and the number of exams, x-rays, cleanings, and other procedures allowed in a certain time period vary by plan. Contact the plans directly for details. (Dental plan phone numbers are listed on page 2.)

If you are receiving continuous dental treatment (such as orthodontia) and are considering changing plans, contact the plans directly to find out if they cover your continuous dental treatment if you enroll in their plan.

Dental Benefits Comparison

(For more details on benefits and exclusions, contact the plans.)

Benefits	Preferred provider organization: Uniform Dental Plan	Managed-care dental plans: DeltaCare Willamette Dental
Annual deductible	Enrollee pays $50 per person/ $150 per family, except for diagnostic and preventive	No deductible
Annual maximum	$1,750 plan reimbursement per person; except as otherwise specified for orthodontia, nonsurgical TMJ, and orthognathic surgery	No general plan maximum
Dentures	50%, PPO and out of state; 40%, non-PPO (dental plan payment)	Enrollee pays $140 copay, complete upper or lower
Endodontics (root canals)	80%, PPO and out of state; 70%, non-PPO (dental plan payment)	Enrollee pays between $100 and $150 copay
Nonsurgical TMJ	70%; $500 lifetime maximum (dental plan payment)	70%; $1,000 annual maximum and $5,000 lifetime maximum (dental plan payment)
Oral surgery	80%, PPO and out of state; 70%, non-PPO (dental plan payment)	Extraction of erupted teeth: Enrollee pays between $10 and $50 copay
Orthodontia	50%; $1,750 lifetime maximum (dental plan payment)	Maximum enrollee copay per case: $1,500
Orthognathic surgery	70%; $5,000 lifetime maximum (dental plan payment)	70%; $5,000 lifetime maximum (dental plan payment)
Periodontic services	80%, PPO and out of state; 70%, non-PPO (dental plan payment)	Enrollee pays between $15 and $100 copay
Preventive/ diagnostic	100%, PPO; 90%, out of state; 80%, non-PPO (dental plan payment)	100% (dental plan payment)
Restorative crowns	50%, PPO and out of state; 40%, non-PPO (dental plan payment)	Enrollee pays between $100 and $175 copay
Restorative fillings	80%, PPO and out of state; 70%, non-PPO (dental plan payment)	Enrollee pays between $10 and $50 copay

Blue ink indicates information only for subscribers who have dental coverage.

General Dental Exclusions

DeltaCare

The following services are not covered:

1. General anesthesia, intravenous, and inhalation sedation, and the services of a special anesthesiologist, except that coverage will be provided for general anesthesia services in conjunction with any covered dental procedure performed in a dental office if such anesthesia services are medically necessary because the enrollee is under the age of 7, or physically or developmentally disabled.
2. Cosmetic dental care. Cosmetic services include, but are not limited to, laminates, veneers, or tooth bleaching.
3. Services for injuries or conditions which are compensable under workers' compensation or employers' liability laws, and services which are provided to the eligible person by any federal, state, or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
4. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such procedures include restoration of tooth structure lost from attrition, abrasion, or erosion without sensitivity and restorations for malalignment of teeth.
5. Application of desensitizing agents.
6. Experimental services or supplies. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation.
7. Dental services performed in a hospital and related hospital fees. However, this exclusion will not apply and benefits will be provided for services rendered during such hospital care, including outpatient charges, if all these requirements are met:
   a. A hospital setting for the dental care must be medically necessary.
   b. Expenses for such care are not covered under the enrollee's employer-sponsored medical plan.
   c. Prior to hospitalization, a request for preauthorization of dental treatment performed at a hospital is submitted to and approved by the plan. Such request for preauthorization must be accompanied by a physician's statement of medical necessity.

   If hospital or facility care is approved, available benefits will be provided at the same percentage rate as those performed by a participating dental provider, up to the available benefit maximum.
8. Loss or theft of fixed or removable prosthetics (crowns, bridges, full or partial dentures).
9. Dental expenses incurred in connection with any dental procedure started after termination of eligibility of coverage.
10. Dental expenses incurred in connection with any dental procedure started prior to the enrollee's eligibility, except for orthodontic services.
11. Cysts and malignancies.
12. Laboratory examination of tissue specimen.
13. Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient management drugs, such as pre-medication and nitrous oxide.
14. Cases which, in the professional judgment of the attending dentist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded.
15. Prophylactic removal of impactions (asymptomatic, nonpathological).
16. Specialist consultations for non-covered benefits.
17. Orthodontic treatment which involves therapy for myofunctional problems, TMJ dysfunctions, micrognathia, macroglossia, cleft palate, or hormonal imbalances causing growth and developmental abnormalities.
18. All other services not specifically included on the patient's copayment schedule as a covered dental benefit.
19. Treatment of fractures and dislocations to the jaw.
20. Dental services received from any dental office other than the assigned dental office, unless expressly authorized in writing by DeltaCare (WDS) or as cited under "Emergency Care or Urgent Care" in DeltaCare's certificate of coverage.

Uniform Dental Plan

General Limitations

1. Dentistry for cosmetic reasons is not a covered benefit. Cosmetic services include, but are not limited to laminates, veneers, or tooth bleaching.
2. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such procedures

General Dental Exclusions

include restoration of tooth structure lost from attrition, abrasion or erosion and malalignment of teeth.

3. General anesthesia, intravenous, and inhalation sedation are not a covered benefit except that coverage will be provided:
   a. When in conjunction with covered oral surgery, endodontic and periodontal surgical procedures; and
   b. For general anesthesia services in conjunction with any covered dental procedures performed in a dental office if such anesthesia services are medically necessary because the enrollee is under the age of 7, or physically or developmentally disabled.

General Exclusions

In addition to the specific exclusions and limitations stated elsewhere in the booklet, UDP does not provide benefits for:

1. Application of desensitizing medicaments.
2. Services or supplies that the Uniform Dental Plan determines are experimental or investigative. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/ observation.
3. Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient-management drugs, such as premedication and nitrous oxide.
4. Hospital or other facility care for dental procedures, including physician services and additional fees charged by the dentist for hospital treatment. However, this exclusion will not apply and benefits will be provided for services rendered during such hospital care, including outpatient charges, if all these requirements are met:
   a. A hospital setting for the dental care must be medically necessary.
   b. Expenses for such care are not covered under the enrollee's employer-sponsored medical plan.
   c. Prior to hospitalization a request for preauthorization of dental treatment performed at a hospital is submitted to and approved by Washington Dental Service. Such request for preauthorization must be accompanied by a physician's statement of medical necessity.

   If hospital or facility care is approved, available benefits will be provided at the same percentage rate as those services performed by a participating dental provider, up to the available benefit maximum.
5. Dental services started prior to the date the person became eligible for services under this plan, except as provided for orthodontic benefits.
6. Services for accidental injury to natural teeth when evaluation of treatment and development of a written plan is performed more than 30 days from the date of the injury. Treatment must be completed within the time frame established in the treatment plan unless delay is medically indicated and the written treatment plan is modified.
7. Expenses incurred after termination of coverage, except expenses for:
   a. Prosthetic devices that are fitted and ordered prior to termination and delivered within 30 days after termination.
   b. Crowns, if the tooth is prepared prior to termination and the crown is seated on the tooth within 30 days after termination.
   c. Root canal treatment, if the tooth canal is opened prior to termination and treatment is completed within 30 days after termination.
8. Missed appointments.
9. Completing insurance forms or reports, or for providing records.
10. Habit-breaking appliances, except as specified under the orthodontia benefit.
11. Full-mouth restoration or replacement of sound fillings. (Replacement of sound fillings will not be covered unless recommended by a licensed dentist, and preauthorization is required.)
12. Charges for dental services performed by anyone who is not a licensed dentist, registered dental hygienist, denturist, or physician, as specified.
13. Services or supplies that are not listed as covered.
14. Treatment of congenital deformity or malformations.
15. Replacement of lost or broken dentures or other appliances.
16. Services for which an enrollee has a contractual right to recover cost, whether a claim is asserted or not, under automobile, medical, personal injury protection, homeowner's or other no-fault insurance.

Blue ink indicates information only for subscribers who have dental coverage.

17. In the event an eligible person fails to obtain a required examination from a Washington Dental Service-appointed consultant dentist for certain treatments, no benefits will be provided for such treatment.

Washington Dental Service shall have the discretionary authority to determine whether services are covered benefits in accordance with the general limitations and exclusions shown in the contract, but it shall not exercise this authority arbitrarily or capriciously or in violation of the contract.

Willamette Dental

The following services are not covered:

1. Dentistry for cosmetic reasons. Cosmetic services include, but are not limited to, laminates, veneers, or tooth bleaching.
2. Restorations or appliances necessary to increase or alter the vertical dimension or to restore the occlusion. Excluded procedures include restoration of tooth structure lost from attrition and restorations for malalignment of teeth.
3. Services or supplies that the plan determines are experimental or investigative.
4. Any drugs or medicines, even if they are prescribed, except as stated in the Prescription Drug Program benefit. This includes analgesics (medications to relieve pain) and patient management drugs, such as pre-medication and nitrous oxide.
5. General anesthesia, intravenous, and inhalation sedation, except that coverage will be provided for general anesthesia services in conjunction with any covered dental procedure performed in a dental office if such anesthesia services are medically necessary because the enrollee is under the age of 7, or physically or developmentally disabled.
6. Hospital or other facility care for dental procedures, including physician services and additional fees charged by the dentist for hospital treatment. However, this exclusion will not apply and benefits will be provided for services rendered during such hospital care, including outpatient charges, if all these requirements are met:
   a. A hospital setting for the dental care must be medically necessary.
   b. Expenses for such care are not covered under the enrollee's employer-sponsored medical plan.
   c. Prior to hospitalization, a request for preauthorization of dental treatment performed at a hospital is submitted to and approved by the plan. Such request for preauthorization must be accompanied by a physician's statement of medical necessity.

   If hospital or facility care is approved, available benefits will be provided at the same percentage rate as those performed by a participating dental provider, up to the available benefit maximum.
7. Dental services started prior to the date the person became eligible for services under this plan.
8. Services for accidental injury to natural teeth that are provided more than 12 months after the date of the accident.
9. Expenses incurred after termination of coverage, except expenses for:
   a. Prosthetic devices that are fitted and ordered prior to termination and delivered within 30 days after termination.
   b. Crowns, if the tooth is prepared prior to termination and the crown is seated on the tooth within 30 days after termination.
   c. Root canal treatment, if the tooth canal is opened prior to termination and treatment is completed within 30 days after termination.
10. Missed appointments.
11. Completing insurance forms or reports, or for providing records.
12. Habit-breaking appliances, except as specified under the orthodontia benefit.
13. Full-mouth reconstruction.
14. Replacement of sound fillings. (Replacement of sound fillings will not be covered unless recommended by a licensed dentist; preauthorization is required.)
15. Charges for dental services performed by anyone who is not a licensed dentist, registered dental hygienist, denturist, or physician, as specified.
16. Loss or theft of fixed or removable prosthetics (crowns, bridges, full or partial dentures).
17. Orthodontic treatment, orthognathic treatment, and treatment of temporomandibular joint (TMJ) disorders that are not authorized in advance by the plan.

Blue ink indicates information only for subscribers who have dental coverage.

Appendix A

2008 Employee Enrollment /Change form for Medical and Dental Coverage

2008 PEBB MEDICAL CONTRACTORS

Aetna Public Employees Plan of Washington, P.O. Box 14089, Lexington, KY 40512-4089
Group Health Cooperative, 320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233
Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
Uniform Medical Plan, P.O. Box 34850, Seattle, WA 98124-1850

2008 PEBB DENTAL CONTRACTORS

DeltaCare, administered by Washington Dental Service, 9706 Fourth Avenue NE, Seattle, WA 98115-2157
Uniform Dental Plan, 9706 Fourth Avenue NE, Seattle, WA 98115-2157
Willamette Dental of Washington, Inc., 11241 Slater Ave. NE, Kirkland, WA 98033

Public Employees Benefits Board (PEBB)

2008 Employee Enrollment/Change

- **List all eligible family members and indicate their enrollment status on this form.**
- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- Attach appropriate **dependent certification** form(s) if required (students age 19 through 23, extended dependents, and dependents with disabilities).

  Forms are available on our website.

Are you making changes to an existing account? ❑ Yes ❑ No	**If yes, what type of changes:** *(Check all that apply.)* ❑ Name ❑ Address ❑ Medical plan ❑ Dental plan ❑ Adding family member ❑ Re-enrollment ❑ Waiving coverage ❑ Termination
Are you or any eligible family members enrolled in PEBB coverage under another account? ❑ Yes ❑ No	

Section 1: Subscriber Information

Social security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Address	Apt./unit number

City	State	ZIP Code	County of residence

Date of birth (mm/dd/yyyy)	Work phone number (including area code) ( )	Home phone number (including area code) ( )

Medical Coverage ❑ Enroll ❑ Waive: date effective_____

Dental Coverage ☒ Enroll (Dental may not be waived.)

If waiving, see Section 6.
Note: If you waive coverage, medical coverage will automatically be waived for all family members.

Section 2: Spouse or Qualified Domestic Partner

*List your eligible spouse or qualified domestic partner and indicate their enrollment status, even if you do not want coverage for them; they **cannot** be enrolled in any other PEBB coverage.*

Relationship to Subscriber

If adding a spouse, please attach a completed *Spouse or Qualified Domestic Partner Certification* form.

If adding a qualified domestic partner, please attach either a completed *Spouse or Qualified Domestic Partner Certification* form, or a copy of your *Certificate of State Registered Domestic Partnership* or registration card and a *Declaration of Tax Status* form.

❑ Spouse: date of marriage _____ ❑ Qualified domestic partner: date established/registered _____

Social security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Address (if different from subscriber)	City	State	ZIP Code

Date of birth (mm/dd/yyyy)	

Medical Coverage ❑ Enroll ❑ Waive: date effective_____

Dental Coverage ❑ Enroll ❑ Waive: date effective_____

If waiving, see Section 6.

Terminate Medical & Dental Coverage

❑ Divorce/Termination of partnership: date of event _____

Please provide his/her new address_____

_____

❑ Death: date of event_____

❑ Other:_____Date effective _____

Visit our Web site at www.pebb.hca.wa.gov

Washington State Health Care Authority
Public Employees Benefits Board
HCA 50-400 (10/07)

Agency name	Agency/subagency	Ins. effective date	Hire date

Section 3: Family Member Information (such as child, etc.)

*List all **eligible** family members and indicate their enrollment status; family members **cannot** be enrolled in any other PEBB coverage. **Use additional forms for more members.*** Please attach appropriate **dependent certification** form if required (students age 20 through age 23, extended dependents, and dependents with disabilities).

A

Relationship to subscriber	❑ Disabled? ❑ Student? (Check only if age 20 or older.)	Sex ❑ M ❑ F	Social security number

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Address (if different from subscriber)	City	State	ZIP Code

Medical Coverage ❑ Enroll ❑ Waive: date effective _____

Dental Coverage ❑ Enroll ❑ Waive: date effective _____

If waiving, see Section 6.

❑ Terminate

Reason _____

Date effective _____

B

Relationship to subscriber	❑ Disabled? ❑ Student? (Check only if age 20 or older.)	Sex ❑ M ❑ F	Social security number

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Address (if different from subscriber)	City	State	ZIP Code

Medical Coverage ❑ Enroll ❑ Waive: date effective _____

Dental Coverage ❑ Enroll ❑ Waive: date effective _____

If waiving, see Section 6.

❑ Terminate

Reason _____

Date effective _____

C

Relationship to subscriber	❑ Disabled? ❑ Student? (Check only if age 20 or older.)	Sex ❑ M ❑ F	Social security number

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Address (if different from subscriber)	City	State	ZIP Code

Medical Coverage ❑ Enroll ❑ Waive: date effective _____

Dental Coverage ❑ Enroll ❑ Waive: date effective _____

If waiving, see Section 6.

❑ Terminate

Reason _____

Date effective _____

Section 4: Medical Plan Selection *Check only one.*

Contact plans for more information; their addresses are shown at the end of this form.

❑ Aetna Public Employees Plan of Washington

Group Health Cooperative

- ❑ Group Health Classic
- ❑ Group Health Value

Kaiser Foundation Health Plan of the Northwest

- ❑ Kaiser Permanente Classic
- ❑ Kaiser Permanente Value

❑ Uniform Medical Plan

Section 5: Dental Plan Selection *Check only one.*

Contact plans for more information; their addresses are shown at the end of this form.

Preferred Provider Organization

❑ Uniform Dental Plan (Group #3000)
(may receive services from any provider)

Managed Care Plans

❑ DeltaCare, administered by Washington Dental Service (Group #3100)
Dentist name or clinic code _____
(must receive services from *DeltaCare provider*)

❑ Willamette Dental of Washington, Inc.
Clinic location _____
(must receive services from *Willamette Dental Group provider*)

Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

Section 6: Signature *Required*

By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB rules, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. My family members and I may also lose PEBB benefits as of the last day of the month we qualified. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, denial of PEBB benefits, and loss of my job.

The PEBB Benefits Services Program will verify eligibility for me and my family members.

If I or my family members choose to waive medical/dental, I understand I can re-enroll within 60 days of adding a new family member, losing other health coverage (with proof of continuous enrollment), or during the annual open enrollment period. If I waive medical for myself, I also waive medical for my family members.

I allow my employer to deduct money from my earnings to pay for the insurance coverage I requested.

This form replaces all previous forms and submissions I have made for PEBB benefits.

HCA's Privacy Notice: We will keep your information private as allowed by law. To see our Privacy Notice, call 360-923-2822 or go to **www.hca.wa.gov**.

Subscriber's signature _____ **Date** _____

Please sign and date this form. Return completed form to your personnel, payroll, or benefits office.

Appendix B

2008 Employee Enrollment /Change form *for Medical Only Groups*

Public Employees Benefits Board (PEBB)

2008 Employee Enrollment/Change

for Medical Only Groups

- **List all eligible family members and indicate their enrollment status on this form.**
- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- Attach appropriate **dependent certification** form(s) if required (students age 19 through age 23, extended dependents, or dependents with disabilities). Forms are available on our Web site.

Are you making changes to an existing account? ❑ Yes ❑ No	**If yes, what type of changes:** *(Check all that apply.)* ❑ Name ❑ Address ❑ Medical plan ❑ Adding family member ❑ Re-enrollment ❑ Waiving coverage ❑ Termination
Are you or any eligible family members enrolled in PEBB coverage under another account? ❑ Yes ❑ No	

Section 1: Subscriber Information

Social security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Address	Apt./unit number

City	State	ZIP Code	County of residence

Date of birth (mm/dd/yyyy)	Work phone number (including area code) ( )	Home phone number (including area code) ( )

Medical Coverage ❑ Enroll ❑ Waive: date effective_____
If waiving, see Section 5.
Note: If you waive coverage, medical coverage will automatically be waived for all family members.

Section 2: Spouse or Qualified Domestic Partner

*List your eligible spouse or qualified domestic partner and indicate their enrollment status, even if you do not want coverage for them; they **cannot** be enrolled in any other PEBB coverage.*

Relationship to Subscriber

If adding a spouse or partner, please attach a completed *Spouse or Qualified Domestic Partner Certification* form.
If adding a qualified domestic partner, please attach either a completed *Spouse or Qualified Domestic Partner Certification* form, or a copy of your *Certificate of State Registered Domestic Partnership* or registration card and a *Declaration of Tax Status* form.

❑ Spouse: date of marriage_____ ❑ Qualified domestic partner: date criteria established/registered_____

Social security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Address (if different from subscriber)	City	State	ZIP Code

Date of birth (mm/dd/yyyy)	

Medical Coverage ❑ Enroll ❑ Waive: date effective_____
If waiving, see Section 5.

Terminate Medical Coverage

❑ Divorce/Dissolution of partnership: date of event _____

Please provide his/her new address_____

_____

❑ Death: date of event_____

❑ Other _____Date effective _____

Visit our Web site at www.pebb.hca.wa.gov

Washington State Health Care Authority
Public Employees Benefits Board
HCA 52-030 (12/07)

Agency name	Agency/subagency	Ins. effective date	Hire date

Section 3: Family Member Information (such as child, etc.)

*List all **eligible** family members and indicate their enrollment status; family members **cannot** be enrolled in any other PEBB coverage. **Use additional forms for more members.** Please attach appropriate **dependent certification** form(s) if required.*

A

Relationship to subscriber	❑ Disabled? ❑ Student? (Check only if age 20 or older.)	Sex ❑ M ❑ F	Social security number

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Medical Coverage ❑ Enroll ❑ Waive: date effective _____ ❑ Terminate Date effective _____

If waiving, see Section 5. Reason _____

B

Relationship to subscriber	❑ Disabled? ❑ Student? (Check only if age 20 or older.)	Sex ❑ M ❑ F	Social security number

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Medical Coverage ❑ Enroll ❑ Waive: date effective _____ ❑ Terminate Date effective _____

If waiving, see Section 5. Reason _____

C

Relationship to subscriber	❑ Disabled? ❑ Student? (Check only if age 20 or older.)	Sex ❑ M ❑ F	Social security number

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Medical Coverage ❑ Enroll ❑ Waive: date effective _____ ❑ Terminate Date effective _____

If waiving, see Section 5. Reason _____

Section 4: Medical Plan Selection *(Check only one.)*

Contact plans for more information; their addresses are shown at the end of this form.

❑ Aetna Public Employees Plan of Washington

Group Health Cooperative

- ❑ Group Health Classic
- ❑ Group Health Value

Kaiser Foundation Health Plan of the Northwest

- ❑ Kaiser Permanente Classic
- ❑ Kaiser Permanente Value

❑ Uniform Medical Plan

Section 5: Signature *(Required)*

By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB rules, I must repay any claims paid by my health plan or premiums paid on my behalf. My family members and I may also lose PEBB benefits as of the last day of the month we qualified. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, denial of PEBB benefits, and loss of my job.

The PEBB Benefits Services Program will verify eligibility for me and my family members.

If I or my family members choose to waive medical, I understand I can re-enroll within 60 days of adding a new family member, losing other health coverage (with proof of continuous enrollment), or during the annual open enrollment period. If I waive medical for myself, I also waive medical for my family members.

I allow my employer to deduct money from my earnings to pay for the insurance coverage I requested.

This form replaces all previous forms and submissions I have made for PEBB benefits.

HCA's Privacy Notice: We will keep your information private as allowed by law. To see our Privacy Notice, call 360-923-2822 or go to **www.hca.wa.gov.**

Subscriber's signature _____ **Date** _____

Please sign and date this form. Return completed form to your personnel, payroll, or benefits office.

2008 PEBB MEDICAL CONTRACTORS

Aetna Public Employees Plan of Washington, P.O. Box 14089, Lexington, KY 40512-4089
Group Health Cooperative, 320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
Uniform Medical Plan, P.O. Box 34850, Seattle, WA 98124-1850

Appendix C

Spouse or Qualified Domestic Partner Certification

Washington State Health Care Authority
Public Employees Benefits Board

Spouse or Qualified Domestic Partner Certification

Complete and return the form(s) in this packet if you want to:

- Add a spouse to your Public Employees Benefits Board (PEBB) coverage, or
- Add a qualified domestic partner to your PEBB coverage.

Adding a Spouse

Remove the *Declaration of Marriage or Qualified Domestic Partnership* form.

Step One:

- Complete Section 1.

Step Two:

- Read and complete Section 3.

Step Three:

- **Employees**: Return the form to your personnel, payroll, or benefits office.
- **All others**: Return the form to the Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684.

Important: Be sure to also submit a completed PEBB enrollment form.

Adding a Qualified Domestic Partner

To add a domestic partner, you may either:

- Complete and return the form(s) in this packet; OR
- **If your same-sex domestic partnership is registered with the Washington Secretary of State's Office:** Send a copy of your Certificate of State Registered Domestic Partnership or registration card as instructed in Step Four below. You must also complete and return the enclosed *Declaration of Tax Status* form. (See Step Two.)

Step One:

- Remove the *Declaration of Marriage or Qualified Domestic Partnership* form. Review and complete Section 2; be sure you meet the five criteria.
- Read and complete Section 3.

Step Two:

- Review the *Declaration of Tax Status* on the back of the form.
- Determine whether your qualified domestic partner fulfills the three requirements listed for Internal Revenue Code (IRC) Section 152 tax eligibility. **Your domestic partner does not need to qualify as an IRC Section 152 dependent to qualify for PEBB coverage.**
- Print your names at the top of the *Declaration of Tax Status* form.
- If you are unsure whether your domestic partner qualifies as an IRC Section 152 dependent, you may confirm eligibility by using the IRC *Worksheet for Determining Dependent Status* form. (See Step Three.)
- Sign, date, and print your social security number on the *Declaration of Tax Status* form.
- If your domestic partner qualifies as an IRC Section 152 dependent, go to Step Four.

Step Three:

- If completing the optional *Worksheet for Determining Dependent Status*, you and your qualified domestic partner will need to know your:
  - Gross monthly income
  - Mortgage/rental payment
  - Monthly expenses for items such as food, utilities, repairs, clothing, education, medical, travel, etc.
- Keep the worksheet for your personal tax records. You do not need to return the worksheet with the other forms.

Step Four:

- **Employees**: Return the forms to your personnel, payroll, or benefits office.
- **All others**: Return the forms to the Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684.

Do **not** return this form; keep for your own tax records.

Worksheet for Determining Dependent Status

This worksheet is modeled on the worksheet in IRS Publication 17 and requests historical information. However, it is necessary that you determine whether your domestic partner will qualify as a dependent for the calendar year the dependent is enrolling (the "enrollment year"). Complete this worksheet using the income and expenses you anticipate during the enrollment year.

Important

You can use this worksheet to determine whether your qualified domestic partner and/or his or her child(ren) also qualify as dependents under Internal Revenue Code (IRC) Section 152 (in general, he or she must receive more than half of his or her support from you).

Income

1. Did the domestic partner you supported receive any income such as wages, interest dividends, pensions, rents, social security, or welfare?
   - ❑ Yes (Answer questions 2, 3, 4, and 5.)
   - ❑ No (Skip to question 6.)
2. Total annual income received $ _____
3. Amount of income used for your domestic partner's support $ _____
4. Amount of income used for purposes other than support $ _____
5. Amount of income either saved or not used for lines 3 or 4 $ _____

The total of lines 3, 4, and 5 should equal line 2.

Yearly household expenses where you and your domestic partner lived

6. Lodging (*Complete either a or b):*
   a. Rent paid $ _____
   b. If not rented, show fair rental value of your home $ _____
   If your domestic partner owned the home, include this amount on line 20.
7. Food $ _____
8. Utilities (heat, light, water, etc. not included in line 6a or 6b) $ _____
9. Repairs that were not included in line 6a or 6b $ _____
10. Other (i.e., furniture). Do not include expenses of maintaining home (i.e., mortgage interest, real estate taxes, and insurance). $ _____
11. Add lines 6a or 6b through 10 $ _____
12. Total number of persons who lived in household $ _____

Yearly expenses for your domestic partner

13. Divide line 11 by line 12 to determine each person's part of household expenses

    $ _____ (line 11) ÷ _____ (line 12) = $ _____ (line 13)

14. Clothing $ _____
15. Education $ _____
16. Medical and dental $ _____
17. Travel and recreation $ _____
18. Other (please specify) _____ $ _____
    _____ $ _____
    _____ $ _____
19. Total amount for your domestic partner's yearly support (Add lines 13 through 18.) $ _____

20. Amount your **domestic partner** provided for his or her own support

Line 3	$ _____
Line 6b (include if your domestic partner owned the home)	$ _____
Add lines 3 and 6b, if each are applicable	$ _____ line 20

21. Amount that others added to your domestic partner's support. Include amounts provided by state, local, and other welfare societies or agencies. Do not include any amounts included on line 2. **$** _____

22. Amount **you** provided for your domestic partner's support:

$ _____ (line 20) + $ _____ (line 21) - $ _____ (line 19) = $ _____ (line 22)

23. 50% of line 19 $ _____

If line 22 is more than line 23, your domestic partner qualifies as an IRC Section 152 dependent. Check "Yes" on the *Declaration of Tax Status* form.

If line 22 is **not** more than line 23, check "No" on the *Declaration of Tax Status* form and consult with your payroll office regarding changes to your taxable income. As a result, the amount **your employer will contribute** for your qualified domestic partner and/or child(ren) is considered taxable by the IRS.

State and higher-education employees: The tables below show the amount that will be added to your total gross income and calculated into your withholding tax. This will be reflected on your pay stub, as well as your *Wage and Tax Statement* (your W-2). The monthly amounts below are rounded to the nearest dollar, consistent with IRS tax reporting.

Employees of K-12 school districts, educational service districts (ESDs), and local government employer groups (cities, counties, municipalities, ports, water districts, etc.): Contact your payroll office for employer contribution amounts.

Active state and higher-education employees

2008 State Contribution for Medical and Dental Coverage for:			
Medical Plan	**Partner**	**Partner's Child(ren)**	**Partner and Child(ren)**
All medical plans	$399	$317	$716
2008 State Contribution for Dental Coverage (Without Medical Coverage) for:			
Dental Plan	**Partner**	**Partner's Child(ren)**	**Partner and Child(ren)**
All dental plans	$40	$40	$80

Health plan comparisons in this document are based on information believed accurate and current, but be sure to confirm information before making decisions.

Retirees who cover a Medicare-enrolled qualified domestic partner will receive a 1099 form from the HCA reflecting the state's contribution toward the domestic partner's medical coverage for the year. The amounts below are rounded to the nearest dollar, consistent with IRS tax reporting.

Medicare retirees

Medical Plan	2008 State Contribution for Medical Coverage for Partner
Aetna Public Employees Plan	$164
Group Health Classic	150
Group Health Value	132
Kaiser Permanente Classic	162
Kaiser Permanente Value	128
Medicare Supplement Plan E Retired	66
Medicare Supplement Plan E Disabled	112
Medicare Supplement Plan J Retired with Rx	133
Medicare Supplement Plan J Disabled with Rx	164
Medicare Supplement Plan J Retired without Rx	90
Medicare Supplement Plan J Disabled without Rx	153
Secure Horizons Classic	164
Secure Horizons Value	136
Uniform Medical Plan	162

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

Declaration of Marriage or Qualified Domestic Partnership

Washington State Health Care Authority
Public Employees Benefits Board

Section 1: Spouse

I, _____ , certify that _____
Print Subscriber's Name — Print Spouse's Name

and I were legally married on _____/____ _____ /_____.
month / day / year

Section 2: Domestic partner

I, _____ , certify that _____
Print Subscriber's Name — Print Qualified Domestic Partner's Name

and I established a domestic partnership beginning _____ / _____/ _____ and we meet the following criteria for a domestic partnership:
month / day / year

1. We have a close personal relationship in lieu of a lawful marriage.
2. We are not married to anyone.
3. We are each other's sole domestic partner and are responsible for each other's common welfare.
4. We are not related by blood as close as would bar marriage.
5. We are domestic partners who are barred from a lawful marriage. (This includes partners of the same sex, or if one or both partners are transgender.)

Subscribers are advised to consult an attorney regarding the possibility that the filing of this declaration may have other legal and/or financial consequences, including the fact that it may, in the event of the termination of the domestic partnership, be regarded as a factor leading a court to treat the relationship as the equivalent of marriage for the purposes of establishing and dividing community property, assigning community debt, and for the payment of support.

Section 3: Signature (required)

By signing this form, we declare that the information we have provided is true, complete, and correct. If it isn't, or if we do not update this information within the timelines in PEBB rules, we must repay any claims paid by our health plan(s) or premiums paid on our behalf. We may also lose PEBB benefits as of the last day of the month we qualified. In addition, we understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, denial of PEBB benefits, and loss of the subscriber's state job.

We understand that:

- Subscribers may add a new spouse or qualified domestic partner within 60 days of marriage or establishment of a qualified domestic partnership, or during a special or annual open enrollment period.
- This declaration shall be terminated upon death of the spouse or qualified domestic partner, or by change of circumstance attested to in this declaration.
- Employees agree to notify their personnel, payroll, or benefits office, and retirees and self-pay members agree to notify the PEBB Benefits Services Program at 1-800-200-1004 if there is any change in the marriage or domestic partnership within 60 days of the change.

HCA's Privacy Notice: We will keep your information private as allowed by law.
To see our Privacy Notice, call 360-923-2822 or go to **www.hca.wa.gov**.

Subscriber's Signature	Social Security Number (- -)	Date
Spouse or Qualified Domestic Partner's Signature	Social Security Number (- -)	Date

Agency use only	Agency	Subagency

Declaration of Tax Status

I, _____ , have completed a *Declaration of Marriage or Qualified Domestic Partnership*
Print Subscriber's Name
form or have registered my same-sex domestic partner with the Washington Secretary of State's Office and have sworn that _____ is my qualified domestic partner.
Print Qualified Domestic Partner's Name

I understand that my employer has a legitimate need to know the federal income tax status of my relationship. I understand that a domestic partner is considered an Internal Revenue Code (IRC) Section 152 dependent **only if each** of the following requirements is met (does **not** affect your domestic partner's eligibility for PEBB coverage):

1. The domestic partner and I live together (share our principal abode) for the full taxable year, except for temporary absences for reasons such as vacation, military service, or education. In other words, my domestic partner and I must live together from January 1 through December 31.
2. The domestic partner is a citizen or resident of the United States.
3. The domestic partner receives more than half of his or her support from me. The rules for determining support are complicated and are more involved than just determining who is the "primary breadwinner." Enclosed is a worksheet similar to one the Internal Revenue Service (IRS) includes in its Publication 17 that you can use to determine whether you provide, or expect to provide, more than half of your domestic partner's support.

Please note:
Even if the above requirements are met, an individual cannot be considered an IRC Section 152 dependent if the relationship violates local law.

Check one of the following boxes; **coverage is only available** if you check a box. Since the above is a summary of complex tax rules, we recommend you consult with your tax advisor regarding your specific circumstances. I declare that:

❑ **Yes**, my domestic partner **is,** or is reasonably expected to be, my Internal Revenue Code Section 152 dependent for the 20___ calendar year.

❑ **No**, my domestic partner is **not,** or is not expected to be, my Internal Revenue Code Section 152 dependent for the 20___ calendar year. As a result, premium contributions for my domestic partner cannot be taken on a pre-tax basis (under IRC Section 125), and the fair market value of the benefits my employer provides for my partner will be added to my taxable income.

❑ **Yes**, my domestic partner's child(ren) as named below **are,** or are reasonably expected to be, my Internal Revenue Code Section 152 dependent(s) for the 20___ calendar year.

Child(ren)'s name(s) _____

❑ **No**, my domestic partner's child(ren) as named below **are not,** or are not expected to be, my Internal Revenue Code Section 152 dependent(s) for the 20___ calendar year. As a result, premium contributions for my domestic partner's eligible family members cannot be taken on a pre-tax basis (under IRC Section 125), and the fair market value of the benefits my employer provides for my partner will be added to my taxable income.

Child(ren)'s name(s) _____

By signing this form:
I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB rules, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. My family members and I may also lose PEBB benefits as of the last day of the month we qualified. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, denial of PEBB benefits, and loss of my job.

I understand that:

- This declaration of responsibility may have legal implications under federal and/or state law.
- A civil action may be brought against me for any losses, including reasonable attorney's fees, if I have made a false statement in this declaration.
- I must notify my personnel, payroll, or benefits office (employees) or the PEBB Benefits Services Program (retirees and self-pay members) if there is a change in the domestic partnership or dependent status within 60 days of the change. *Any change in my family status may directly impact the calculation of my taxable income.*

HCA's Privacy Notice: We will keep your information private as allowed by law.
To see our Privacy Notice, call 360-923-2822 or go to **www.hca.wa.gov**.

_____ - - _____ _____
Subscriber's Signature | Social Security Number | Date

Washington State
Health Care Authority
Public Employees Benefits Board

www.pebb.hca.wa.gov